REFERRAL WAIVER FORM

Auburn Westboro Eye Associates

4 Lyman St, Westboro, Massachusetts 01581
Telephone: (508)366-7461 Fax: (508)366-5018

Patient's Name (print) ______________________________

Date of Birth______________________________

Date of service______________________________

Specialty care must be approved by your Primary Care Provider (PCP). Your signature below indicates that if you receive specialty care without a referral from your PCP, you may be financially responsible for the services received.

- ☐ Dr Suzanne Lucash, Optometrist **NPI 1053422592**
- ☐ Dr Jeffrey Cohn, Optometrist **NPI 1316292162**
- ☐ Dr Rebecca McLaughlin, Optometrist **NPI 1639564180**
- ☐ Dr Michael Cohn, Optometrist **NPI 1548377393**
- ☐ Dr Brenda Komari, Optometrist **NPI 1588154835**

Signature: ______________________________

Date: ______________________________

NOTE: If you ask your PCP to specify, most insurances will authorize 6 visits to cover future visits within one year with the same specialty doctor. Fax referral to: (508) 366-5018

Primary Care Doctor______________________ **Tel No**____________

Address______________________________