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Waiver of Liability / Financial Disclaimer

The purpose of this letter is to help you make an informed choice whether or not you want to receive these services knowing you may have to pay for them yourself. Before you make any decision about your options you should:

Read this entire notice carefully.

Ask us to explain if you do not understand why your insurance may not pay.

Ask us how much these services or items may cost to you.

Estimated Cost: \$

Description of Services:

_____ In the event my insurance coverage is not in effect, I understand I may be financially responsible for the medical service received.

_____ I understand my Physician has not received a referral authorization from my insurance carrier via primary care physician and I may be responsible for the medical services I receive.

Name of Insurance Plan

ID Number

Primary Care Physician's Name

Primary Care Physician's Office Number

Please Print Patient Name

NW ENT & Allergy Account Number

X _____ / /
Signature of Patient or Person Assuming Financial Res (if other than patient) Date

If Patient's Representative, signed on behalf of: _____
Please Print Name of Patient Representative

Description on representative's Authority:

Attach documentation of legal authority, if Legal Guardian or Holder of Power of Attorney.