Lazarou Urology Associates, PC
Office: 781-237-9000 Fax: 781-237-9001

Referral Release

I understand that I need a referral from my primary care physician for today's appointment. I understand that it is my responsibility to obtain this referral. If I do not obtain a referral from my primary care physician, I am responsible for any charges made to my account for my treatment.

*This does not apply to patients with PPO plans.

Health Insurance Waiver for Non-Covered Services

I understand that my health insurance may not cover certain services provided by Dr. Lazarou. Services not covered by your insurance will be billed to you. Should you have any questions regarding your coverage, it is your responsibility to verify your benefits with your insurance company prior to any scheduled appointment.

Authorization for Health Plan to Pay Directly to Physician

I authorize payment from my insurance carrier directly to the health care providers at Lazarou Urology Associates.

Name:_____

Date:_____