

**Orthopaedic Associates of Southern Delaware, P.A.**  
**17005 Old Orchard Road**  
**Lewes, Delaware 19958**  
**Phone (302) 644-3311 Fax (302) 644-3300**

**REFERRAL POLICY**

If your insurance policy requires a referral (To know for sure, check your insurance policy member handbook or contact members services to find out if you need a referral. The number is located on the back of your card.), you are required to have the referral at the time of your office visit in order for your insurance company to pay for the services you received at Orthopaedic Associates of Southern Delaware, P.A. **Failure to have this referral may result in your office visit being rescheduled or you will have to pay up front before services are rendered.**

As a courtesy to you, our staff will make one telephone call to you as a reminder of needing the referral and one telephone call to your listed primary care physician (PCP). If at the time of your appointment you do not have your referral, we will allow approximately 15 minutes for you to contact your PCP and have the referral faxed to us. If after 15 minutes we do not have the referral, you will be given the choice of rescheduling your appointment or paying for today's visit (which must be paid in full before you can see the physician/physician assistant).

As a specialty practice, we are aware of emergencies. If this is the case as determined by Orthopaedic Associates of Southern Delaware, P.A., we will contact your PCP again to try to obtain your referral or have you sign a payment arrangement plan so you may receive the care you need.

Please have your referral ahead of time. This will not only aid Orthopaedic Associates of Southern Delaware, P.A., in getting you seen in a timely manner but also keep our schedule running smoothly for our other patients waiting to be seen.

Thank you in advance for helping us to receive your referrals as this will assist us in getting your bills paid by your insurance company.

**My signature below verifies that I have read and understand the above referral policy. I also understand that it is my responsibility to obtain my referral in order for my insurance company to make payment for my office visit with Orthopaedic Associates of Southern Delaware, P.A.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient/Guardian Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Witness Name

A copy of this referral Policy has been given to the patient       Yes       No