

# Westchester Health Associates, P.L.L.C.

60 Goldens Bridge Road  
 Katonah, NY 10536  
 (914) 232-3255

PATIENT INFORMATION					
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)				
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		HOME PHONE		
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
CITY, STATE ZIP		DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I, the undersigned, hereby certify that I have insurance coverage and assign all insurance benefits to Westchester Health Associates, if any, for services rendered. I understand that I am responsible for all co-payments/co-insurance, deductibles and otherwise elective non-covered services provided to me (or my dependents). I authorize Westchester Health Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I, the undersigned, hereby agree that I am financially responsible for all services provided to me by Westchester Health Associates.

\_\_\_\_\_  
 SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
 DATE