Westchester Health

60 Golden's Bridge Rd
Katonah, NY 10536

Patient Name:_____

Provider Name:_____

Date of Service:_____

Encounter # _____

Non-Covered Service: _____

I understand that my Insurance Carrier DOES NOT COVER the above noted service (s).

I understand that I am responsible for payment, at the time of service, in the amount of:

$_____

I_____

Have read and understand the above waiver of liability, and agree to make payment in full at the time of service.

Patient Signature_____

Date_____