



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 _____