John Viscovich, DPM

101 South Bedford Road, Ste. 213
Mt. Kisco, NY 10549
914-244-0244

356 Route 202
Somers, NY 10589
914-276-6060

465 Columbus Ave., Ste. 125
Valhalla, NY 10595
914-244-0244

Financial Waiver

Date: __/__/____

Print Patient Name: _____ Date of **Birth**: __/__/____

Service Description

Procedure: _____ Description: _____ Cost: $_____

Product/Item: _____ Description: _____ Cost: $_____

Patient will be financially responsible for the following:

- All co-payments, co-insurance and/or deductibles
- All referrals (if applicable) not obtained or not on file with your healthcare carrier
- Non-allowable expenses outlined in your healthcare contracts
- All over-the-counter products
- All services rendered without insurance coverage
- All services rendered out-of-network

I hereby affirm that I have been informed and I understand that these services/products may be excluded or excludable under my health plan. By signing this waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with any of the aforementioned services/products described above.

Patient Signature: _____ Date: __/__/____

OR

Print Patent/Legal Guardian: _____ Date: __/__/____

Parent/Legal Guardian Signature: _____ Date: __/__/____

Witness Signature: _____ Date: __/__/____