Westchester Health Medical PC
Member of Northwell Health Physician Partners
190 Goldens Bridge Rd
Katonah, NY 10536

Patient Name: _____

Provider Name: _____

Date of Service: _____

Encounter # _____

_____ MY INSURANCE CARRIER DOES NOT COVER THE ABOVE NOTED SERVICE(S). I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF THESE SERVICE(S). MY INSURANCE WILL BE BILLED, AS A COURTESY, AND I WILL BE REIMBURSED IF THE INSURANCE MAKES PAYMENT.

_____ THE ABOVE NOTED SERVICE(S) IS BEING PROVIDED BY A NON-PARTICIPATING PROVIDER. I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY FOR THESE SERVICE(S) IN FULL AND THAT MY INSURANCE WILL NOT BE BILLED FOR THESE SERVICES.

I_____

Have read and understand the above waiver of liability, and agree to pay for any services.

Patient Signature_____

Date_____ Insurance Carrier_____