Scarsdale Medical Group | White Plains Hospital

ADMINISTRATIVE OFFICE
550 Mamaroneck Avenue
Suite 302, Harrison, NY 10528

T: (914) 723-8100
F: (914) 940-6546
scarsdalemedical.com

GENERAL WAIVER

Acknowledgement for all Non-Par Insurances or Self-Pay patients effective 1/1/2019

Scarsdale Medical Group is contracted with a variety of health insurance plans. I have been informed and fully understand that Scarsdale Medical Group is not contracted with and **does not** participate with my health insurance plan; therefore, the services rendered today may not be covered by my health insurance plan. Should the services provided not be covered, I will be personally responsible for payment as it is my decision to request to be seen at the Scarsdale Medical Group.

Patient Name: _____ Date of Birth: _____

Date of Service: _____

Medical Insurance Plan Name: _____

Policy ID #: _____

Provider Being Seen Today: _____

Representative Name (Please print): _____

I understand that although Scarsdale Medical Group does not participate with my insurance plan, this does not mean a refusal of treatment. I, the patient have the right to receive services at a non-participating facility.

I have been made aware that any billing statements pertaining to my visit today will be sent to my billing address and that it is my responsibility to follow up and ensure that payment is made for services rendered by Scarsdale Medical Group. If my insurance plan does not pay the outstanding balance(s), I, the patient will be held responsible for payment, but may be eligible to receive a discount off the retail rate as a courtesy provided by Scarsdale Medical Group, upon contacting the billing department directly at (914) 989-1186.

By signing below, I acknowledge that I have read and understand the above fully.

I understand all of the above, accept my responsibilities as a patient, and still wish to receive services provided by the Non-Participating Provider today.

Signature of Patient/Guardian: _____

Date: _____

Signature of Witness: _____

Date: _____