Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

Please bring all completed forms to your appointment

Waiver of Liability Form – Self Pay

Date: _____ Patient Name: _____

Insurance provider: _____

NOTE: You must make a choice about receiving these health care services

Your insurance only pays for covered items and services when certain conditions are met. If you decide to have services without the necessary insurance requirements, you may have to pay for them yourself. Your insurer may not pay for:

Service: _____

Because: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you might have to pay for them yourself. The fact that your insurance may not pay for a particular service does not mean that you should not receive the service recommended by your doctor. Before you make any decision about your options, you should:

- Read this entire notice carefully.
- Ask us to explain if you do not understand why your insurer may not pay.
- Ask us how much these services will cost (estimate: _____). ***Note that this payment is due at the time of service***

PLEASE CHOOSE ONE OPTION. SIGN & DATE YOUR CHOICE.

□ **YES.** I want to receive these services, but **do not bill my insurance carrier or I do not have insurance coverage** and therefore will be considered a self-pay patient. I am agreeing to assume ALL financial responsibility and understand that I will be asked to pay at the time of service. I understand that Weill Cornell Imaging at NewYork-Presbyterian will not be able to submit a claim to my insurance on my behalf.

□ **NO.** I have decided that I will not receive these services.

_____ _____

Signature of patient or person acting on patient's behalf **Date**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance, your health information on this form may be shared with your insurance provider.