Weill Cornell Imaging

NewYork-Presbyterian Weill Cornell Medicine

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Please bring all completed forms to your appointment

Waiver of Liability Form – Insurance Off-Hours

Date: _____ Patient Name: _____

Insurance provider: _____

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

Your insurance may not pay for the service described below. Your insurance only pays for covered items and services when certain conditions are met, but 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. 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. 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: _____) in case you have to pay for them yourself.

PLEASE CHOOSE ONE OPTION. SIGN & DATE YOUR CHOICE.

□ **YES.** I want to receive these services. Please submit a claim to my insurance. I understand that undergoing this service, though ordered by my doctor, may not be covered by my insurance, and therefore you may bill me for it. If my insurance denies payment, I agree to be personally responsible for payment. I understand that I may appeal my insurance's decision.

□ **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

□ **NO.** I have decided that I will not receive these services. I understand that you will not be able to submit a claim to my insurance on my behalf.

_____ _____

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.