ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Patient Name ________________________________ DOB:____________

Account# _________________________

Date of Service ___________________

Dear Patient:

This is to inform you that your Commercial Insurance, Medicaid carriers may not cover **the services for White Plains Hospital Center**.

The hospital will submit a claim on your behalf, however if your insurance company rejects the claim we will bill you for the charges incurred. You will be responsible for the payment to White Plains Hospital.

I acknowledge that I have read this form, that I agree to have the services set forth above performed by the Hospital, and that I will be personally responsible for the Hospital charges or any balance not covered by my insurance company.

____________________________________ _____________________

Signature of Patient or Representative Date