



222 N. Westchester Avenue, Suite 202, White Plains, NY 10604
Phone: 914-761-1717 Fax: 914-761-1711

Patient's Name: _____ Date of Birth: _____

Policy Holder: _____	Date of Birth: ____--____--____
Primary Insurance: _____	Policy ID: _____
SSN: _____ -- _____ -- _____	

I, _____, UNDERSTAND THAT IT IS MY RESPONSIBILITY TO SELECT DR. ROSS, DR. AVVOCATO, DR. EISENBERG or DR. WURZEL AS MY CHILD'S PRIMARY CARE PHYSICIAN WITH MY INSURANCE COMPANY PRIOR TO VISIT. FAILURE TO NOTIFY MY INSURANCE COMPANY MAY RESULT IN ANY INCURRED CHARGES BEING MY FINANCIAL RESPONSIBILITY.

Permission to Release Medical Information & Assignment of Benefits

I have read this form and declare that all information given by me is known to be valid and true. I have read and understand the payment policy of **Westchester Park Pediatrics** and agree to their terms. A photocopy of this release/assignment may be used in lieu of the original.

I hereby authorize payment be made directly to **Westchester Park Pediatrics** for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered to me or to my dependents.

I authorize the above noted doctor and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Parent/Guardian Signature: _____ Date: _____

Payment Policy

Not Insured: If you do not have insurance coverage, please understand that payment is **due in full at the time of service**. We accept payment by check, cash or credit card.

Returned Check Policy: We will accept personal checks. However, if the check is returned for insufficient funds, a **\$25.00** returned check fee will be added to the patient's account. In addition, all future payments must be made in cash or by a credit card.

Co-Pay Policy: As per your insurance company, you are required to pay your co-pay at the time service is rendered. Please note that a **\$20.00** processing fee will be added to the patients account for each co-pay that is not paid at the time of service.

Referral Policy: If your insurance company requires a referral to visit a specialist, it is your responsibility to notify Westchester Park Pediatrics 48 hours prior to your appointment so that we can process the referral. You will need to obtain the specialist's full contact information in order to process your referral. Same day referrals will only be issued in a medical emergency.

Cancellation Policy: There is a 24 hour notification policy for all cancelled appointments. If an appointment is missed without proper notification, a **\$40.00** charge will be added to the patient's account.

Parent/Guardian Signature: _____ Date: _____