NYU Faculty Group Practice

Non-Participating Plans

Pre-Payment Financial Acknowledgment Form

Date:	Patient Name:
Patient MR #:	Physician:
Expected Date of Service:	Estimated Cost:
Deposit Amount:	Insurance Plan:

FINANCIAL AGREEMENT

I have been advised by the NYU Faculty Group Practice that my physician does not participate with my insurance plan and therefore, I will be fully responsible for the cost of services. I am choosing to have the above services rendered and have been provided with an estimate of the total cost for my physician's services. I am aware that the amount quoted above is an estimate and that actual charges may vary. I also understand that there may be additional costs for ancillary services (radiology, anesthesia, pathology, etc.) that are not included in this estimate. A courtesy claim will be sent to my insurance carrier on my behalf.* I will be billed for and responsible for any remaining balances.

I understand that all balances are due upon receipt of statement from NYU.

I have read the above information and I understand my financial obligations.

_____ _____

Signature **Date**

*If my insurance carrier sends payment to me for the service I will immediately remit the payment to the NYU Faculty Group Practice.