NYU Langone MEDICAL CENTER

NYU Faculty Group Practice

Non-Participating Plans/Cosmetic/Self-Pay/Non-Covered Services

Patient Estimate

Date:	Patient Name:
Patient MRN:	Provider:
Expected Date(s) of Service(s):	Description of Service(s):
Estimated Cost:	Insurance Plan:
Prepayment Amount:	Estimated Balance:

FINANCIAL AGREEMENT

I have been advised by the NYU Faculty Group Practice that my physician does not participate with my insurance plan and/or I am receiving services that may not be covered by my insurance plan or I am uninsured; therefore, I will be fully responsible for the cost of services rendered by my physician. I acknowledge that I am choosing to have the above services rendered and may be provided with an estimate of the total cost for my physician's services upon request. I understand that I am expected to pay the estimated fee prior to the services being rendered. I am aware that any amount quoted to me is an estimate only and that actual charges may vary. I am also aware that there may be additional costs for ancillary services (i.e., radiology, anesthesia, pathology, etc.) that are not included in the estimate. I understand that I will be billed for and responsible for any remaining balances.

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

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

_____	_____	_____
Guarantor/Patient Name	**Guarantor/Patient Signature**	**Date**

Revised: 9-2-15