10 Chester Avenue, White Plains, NY 10601
(914) 448-1000

Authorization and Release

Authorization and Treatment: I voluntarily consent to the administration and cost of the medical and surgical procedures for myself and my dependents.

Assignment of Insurance Benefits: I authorize payment directly to White Plains Walk-in Medical Care, PLLC for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that insurance is accepted, I must pay all applicable insurance co-pays, coinsurance, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for the service.

Release of Records: I authorize White Plains Walk-in Medical Care, PLLC to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or any health care operations which may be liable to me or my practitioner(s) for charges for treatment and quality management, utilization review, transfer and follow-up purposes.

Receipt of Privacy Policy: I acknowledge that I have received and read the Notice of Privacy Practices of White Plains Walk-in Medical Care, PLLC. I understand that a copy of this agreement may be used with the same effectiveness as the original. I understand how my protected health information can be used to carry out treatment, payment, and healthcare operations as permitted under Federal regulations.

Facebook and Social Media: I acknowledge that if I post my protected health information on Facebook or Other social media and internet sites, I do so voluntarily and this information will be viewed by broad audience of people.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Consent for notification of test results

I give permission to White Plains Walk-in Medical Care, PLLC to notify _____

my health Information. Relationship: _____

Patient Signature: _____ Date: _____

I give permission to White Plains Walk-in Medical Care to leave any health information on my answering machine.

Patient Signature: _____ Date: _____