WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
Cedarwood Hall
Valhalla, NY 10595-1681

NAME _____

D.O.B. _____

WMC # _____ **WIHD#** _____
(For WIHD Use Only)

FINANCIAL STATEMENTS FORM

FINANCIAL AGREEMENTS

1. **Release of Information:**
I hereby authorize and direct the Westchester Institute for Human Development to release to governmental agencies, insurance carriers, or others who are, or may be, financially responsible for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to my care and treatment.

DATE: _____ SIGNATURE: _____
Patient or Responsible Person

2. **Assignment of Benefits and Guarantee of Payment:**
I hereby authorize and direct my insurance carrier to make payment directly to the Westchester Institute for Human Development, and hereby assign to said institute, all rights, title and interests I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by said institute. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE-NAMED INSTITUTE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR IN MY BEHALF. However, if treatment has been given in accordance with New York State's No-Fault law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee schedules. I hereby authorize and direct the above-named institute and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance carriers and other payers.

DATE: _____ SIGNATURE: _____
Patient or Responsible Person

IF PERSON OTHER THAN PATIENT SIGNS, INDICATE RELATIONSHIP TO PATIENT AND REASON FOR LACK OF PATIENT SIGNATURE: _____

3. **Medicare Insurance:**
I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information regarding my treatment, to release to the Social Security Administration and/or the Centers for Medicare & Medicaid Services or its intermediaries or carriers, any information needed for this related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare in my behalf.

DATE: _____ SIGNATURE: _____
Patient or Responsible Person

4. **I HAVE READ THIS AGREEMENT, AND I FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE. I HAVE RETAINED A COPY OF THIS AGREEMENT.**

DATE: _____ SIGNATURE: _____
Patient or Responsible Person (parent if minor)