SPECTRUM PHYSICAL THERAPY & CHIROPRACTIC, PLLC

3272 Hempstead Turnpike
Levittown, New York 11756

<u>GUARANTEE AGREEMENT</u>

I. **<u>INDIVIDUAL'S RESPONSIBIILTY FOR NON-COVERED SERVICES</u>**:

In consideration of services rendered by <u>SPECTRUM PHYSICAL THERAPY & CHIROPRACTIC</u> to the undersigned patient, the undersigned promise(s) to pay to <u>SPECTRUM PT & CHIRO</u> any copayment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan provided I am informed of the same prior to the rendering of said services.

II. **<u>ASSIGNMENT OF BENEFIT PROCEEDS</u>**:

I hereby assign to <u>SPECTRUM PT & CHIRO</u> all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payor, government agencies, or those who are financially liable for my medical care.

III. **<u>AUTHORIZATION TO RELEASE RECORDS</u>**:

I hereby authorize <u>SPECTRUM PT & CHIRO</u> to release to my insurer/HMO/third-party payor, governmental agencies, or to whomever is financially responsible for my medial care, all information needed to substantiate payment for such medical care and, if required, for pre-certifications/prior approval purposes.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services which are not MEDICALLY NECESSARY or improperly billed.

Once your insurance coverage is qualified, this office will accept it on assignment. This means we will bill your insurance company directly. The insurance company usually will mail payment directly to this office. ***<u>If the insurance company mistakenly makes a payment directly to you, the original check, along with the explanation of benefits, must be brought to this office within seven (7) days of receipt.</u>*** Failure to bring in the check will hold you responsible for that payment PLUS any legal fees incurred by trying to collect any delinquent account.

I have read the above and will abide by it.

_____   _____
Signature of Patient or   Date
Authorized Representative   *guarantee.agrmt*