Date ____________________

I/We hereby agree as follows:

1. **Guaranty of Payment.** Medical care has been or will be provided to the patient whose name appears below. I/We, both jointly and individually, shall be responsible for payment for the patient's physician bill, based upon the physician's posted charges. The physician may demand full payment of the patient's bill at any time. If the physician doesn't demand immediate payment, my/our obligation to make such payment remains the same.
2. **When the Patient's Insurance Coverage is Insufficient.** If any insurance coverage which the patient may have, such as Blue Cross Blue Shield, Exclusive Care, Medicare, Medicaid, compensation or other coverage, rejects the patient's claim, or allows only part of the claim and states that it is the patient's responsibility, I/We shall be responsible for the immediate payment of the balance due, as determined by the physician.
3. **Late Payment Fees.** You may be charged a late payment fee of **$25.00** for all accounts unpaid after 90 days from the date of the insurance payment and are subject to a **5%** annual interest fee thereafter.
4. **Missed appointments.** Unless cancelled 24 hours in advance, we reserve the right to charge for the missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments or call us as soon as you know you will be unable to keep that appointment.
5. **This agreement.** I/We have read and understand this Agreement, and have received a copy as well.

____
Name of patient

____
Witness

____
Name of Person Guarantying Payment

____
Signature

____
Home Address

____
Home Phone Number

____
Employer