



Stony Brook Southampton Hospital

GUARANTEE AGREEMENT

For and in consideration of services rendered or to be rendered by Westhampton Primary Care Center, Physicians or Staff, to the patient whose name appears below, the undersigned (jointly or severally, if more than one) hereby promise(s) to pay to the Westhampton Primary Care Center all charges as submitted by Westhampton Primary Care Center which are not covered in accordance with my insurance plan, together with all collection costs. I/We understand that all bills are payable and become due upon presentation.

I/We hereby assign to Westhampton Primary Care Center Physicians and Staff all monies and/or benefits to which I/we may be entitled from government agencies, insurance carriers or those who are financially liable for medical care to cover the costs of the care and treatment rendered to myself or my dependents.

I/We hereby authorize and direct Westhampton Primary Care Center to release to governmental agencies, insurance carriers or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care.

X _____
Signature of Patient or Authorized Representative

X _____
Date

Witness

FOR PATIENTS ENTITLED TO MEDICARE/MEDIGAP BENEFITS

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 about me to release to the Social Security Administration, Health Care Financing Administration or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for physician services to the physician furnishing the services.

By signing below I acknowledge that this authorization applies to all occasions of service until it is revoked.

Signature of Patient or Authorized Representative

Date

Witness