Stony Brook Medicine

Date: _____

Medical Record #: _____

File#: _____

FINANCIAL AGREEMENT

I/We hereby agree as follows:

1. Guarantee 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 fully responsible for payment of the patient's bill, based on the charges incurred which I/We nowagree are fair and reasonable. The University Faculty Practice Corporations may demand full payment of the patient's bill at any time, but the University Faculty Practice Corporations are not required to do this. Even if the University Faculty Practice Corporations do not 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 Shield, Medicare, Medicaid, Compensation or other coverage, rejects the patient's claim or allows only part of the claim, I/we shall be responsible for immediate payment of the balance due to the extent permitted by law.

3. The Agreement. I/We have read and understood this Agreement and have received a copy as well.

_____
Name of Patient

_____
Name of Person Guaranteeing Payment

_____
Signature of Person Guaranteeing Payment

UNIVERSITY FACULTY PRACTICE CORPORATIONS

_____
Home Address

_____
Telephone Number

_____
Employer's Name

_____
Witness

PA-29g/7-92 8/2009