Stony Brook Medicine

Patient Name: _____ MRN: _____

Group #: _____ Date: _____

Stony Brook Psychiatric Associates

P.O. Box 1559

Stony Brook, NY 11790

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service a is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

I have read and understand this information. understand that my insurance company may deny coverage and request that _____ perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

_____	_____	_____
Signature of Patient or Legally Authorized Representative/Guarantor	Print Name	Date
_____	_____	_____
Signature of Witness	Print Name	Date