FINANCIAL AGREEMENT

Date: _____

I hereby agree to the following:

1. **Guarantee of Payment**: Medical care has been or will be provided to myself whose name appears below. I shall be fully responsible for payment of all bills relating to my medical care, including laboratory or any other ancillary tests ordered by Shoreline Medical Associates. Shoreline Medical Associates may demand full payment of my bill at anytime. Even if the practice does not demand immediate payment my obligation to make such payment remains the same.

2. **When my Insurance Coverage is Insufficient:** If any medical insurance coverage which I may have rejects my medical claim or allows only part of the claim for my medical care, laboratory fees and other ancillary fees, I shall be responsible for any payment due. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges.

3. **This Agreement**: As a courtesy to you, it is the policy of Shoreline Medical Associates to bill your insurance carrier, although you are ultimately responsible for the entire bill. I have read and understand this agreement I have with Shoreline Medical Associates.

_____

Name of Patient

_____

Signature of Patient or Responsible Party