Sun City Medical Partners

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GUARANTEE OF FINANCIAL RESPONSIBILITY FOR PROFESSIONAL SERVICES

I understand that any eligibility for benefit coverage of professional and other services by my health plan is not a guarantee of payment for services rendered to me.

I wish to receive medical services from Sun City Medical Partners at this time.

In the event I am ineligible for benefits from a health plan I understand that I will be fully/personally responsible for all services and supplies provided to me. I will pay all such charges when I am presented with a bill.

In the event I have no health insurance coverage or I refuse to guarantee the financial responsibility, I understand I must pay for all services rendered at the time of service.

Patient Name: _____ Date of Birth: ____ / ____ / ____

Signature: _____ Today's Date: ____ / ____ / ____