

PAUL YERYS, M.D.
JEFFREY MEYER, M.D.
PETER LESNIEWSKI, M.D.



Island Sports Medicine

Orthopedic Surgery
Arthroscopic Surgery
Joint Replacement
Spine Surgery
Trauma Foot &
Upper Extremity

GUARANTEE AGREEMENT

For and in consideration of services rendered by **Drs. Yerys/Meyer/Lesniewski**, to the patient whose name appears below, the undersigned hereby promises to pay **Drs. Yerys/Meyer/Lesniewski** any co-payment, co-insurance or fees required by my coverage with any insurer/HMO or other third party payer. In addition, I promise to pay for all services that are not covered by my benefit plan with any such insurer/HMO/or other third party insurer. I further understand that all bills are payable and become due upon presentation.

I hereby assign to **Drs. Yerys/Meyer/Lesniewski**, all monies and/or benefits to which I may be entitled from my coverage with any insurer/HMO/third party payer/government agencies or those who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents.

If copies of x-rays are necessary and your insurance company does not pay, you will be responsible for any fees incurred for the copies or interpretation of same.

I hereby authorize and direct **Drs. Yerys/Meyer/Lesniewski** to release to any insurer/HMO/third party payer/governmental agencies or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

A service fee of \$10.00 will be added to your bill if we must bill you for your co-payment.

In an effort to keep waiting time to a minimum and to allow us availability of appointments for our patients, a patient will be charged \$30.00 fee for failure to show or cancel scheduled appointments.

(SIGNATURE OF PATIENT, OR PARENT/GUARDIAN)

DATE

(FORMS/GUARANTEE-6-16-05)