HEALTHSOURCE SAGINAW
SAGINAW, MICHIGAN

FINANCIAL AGREEMENT

(To be completed by patient/resident)

For and in consideration of services rendered _____
(Patient/Resident, MR Number, Billing Number)

I, the undersigned patient/resident, in consideration of services rendered or to be rendered by HealthSource Saginaw, hereby agree to make payment of all charges made (if not otherwise covered by hospitalization insurance, and/or a State or Federal assistance program) within thirty (30) days from date of billing. I understand that my benefits have been fully explained to me and that I may receive a copy of the rate schedule if I were to request one.

Date:_____ _____
(Signature of Patient/Resident)

PAYMENT GUARANTEE

(To be completed by party guaranteeing account)

For and in consideration of services rendered to or to be rendered to _____
(Patient/Resident, MR #, Billing #)

I, the undersigned, agree to provide the financial information required for payment from third party Payors and agree to provide patient pay amounts required by third party insurers. I also have been fully able to review and understand the payment schedule set forth by HealthSource Saginaw.

Date: _____

_____ _____
(Guarantor's Signature) (Guarantor's Place of Employment)

_____ _____
(Guarantor's Street Address) (Guarantor's Employer's Address)

_____ _____
(City, State, Zip Code) (City, State, Zip Code)

_____ _____
(Guarantor's Social Security Number) (Home, Cell, & Work Phone #'s)

Date:_____

Witness:_____