PATIENT/GUARANTOR AGREEMENT

1. On my own behalf and on behalf of my spouse and minor children, including stepchildren, I hereby authorize treatment by New York Allergy & Sinus Group, PLLC.
2. I accept responsibility and guarantee payment for all services rendered to me and my family and upon default on any payment due New York Allergy & Sinus Group, PLLC agree to pay all cost of collections including collection agency fees. I understand there is a $25.00 returned check fee should a check be returned for any reason.
3. I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from Medicare, Blue Shield and/or any other agency involved in the payment of my treatment.
4. I also direct and assign payment from said third parties to New York Allergy & Sinus Group, PLLC. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to New York Allergy & Sinus Group, PLLC for any charges not covered by insurance. If payment from my insurance is not received within 120 days, my account will become due and payable by me. Any balance remaining on the account after insurance pays will be due payable by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. Charges not payable by my insurance carrier are due immediately.
5. The possibility exists (during treatment) for healthcare workers to become directly exposed to my blood or body fluids. In the event of such direct exposure, State laws require a sample of my blood to be tested for the presence of infectious diseases. The results of these tests will be released to me and my family and to the healthcare workers who suffered exposure.
6. The assignment/obligations and authorizations set forth in this statement and the insurance assignment shall be binding upon me both for the present treatment and that which may be rendered to me and my family in the future by New York Allergy & Sinus Group, PLLC.
7. I authorize a copy of my New York Allergy & Sinus Group, PLLC medical record to be forwarded to my Primary Care Physician as well as any and all attending or consulting practitioners.

I hereby authorize direct payment to Dr. Morris Nejat and /or New York Allergy & Sinus Group, PLLC (doctor and/or any service supplier) of all insurance benefits otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, including collection fees, court costs, attorney fees, and prejudgment interest at the highest amounts allowed under the law, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the doctor and/or any service supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Patient or Responsible Party | Name of Patient or Responsible Party *(Please Print)* | Date

REFERRAL RESPONSIBILITY

This is to advise you that it is your responsibility, as a patient, to obtain a referral from your primary Care Physician for services rendered. This referral must be dated prior to the time of service. It is also your responsibility to keep track and make a copy of your referrals to be sure that the visits or length of time of the referrals do not run out. If your insurance company requires a referral and it is not obtained, you will be responsible for the payment to the doctor.

Signature of Patient or Responsible Party | Name of Patient or Responsible Party *(Please Print)* | Date

Witness