NORTHERN VIRGINIA
DERMATOLOGY, VEIN & SURGERY CENTER

FINANCIAL AGREEMENT

Date: _____

I/We hereby agree as follows:

1. **Guaranty of Payment**. Medical care has been / will be provided to the patient whose name appears below. I/We shall be fully responsible for the patients' physician bill, based upon the physician's posted charges, which I/we agree are fair and reasonable. The physician may demand full payment of the patients' bill at any time, but the physician is not required to do this. Even if the physician doesn't demand immediate payment, my/our obligation to make such payment remains the same.
2. **When the patients' insurance coverage is insufficient**. If any insurance coverage which the patient may have such as Anthem Healthkeepers Direct Access, Anthem Healthkeepers POS Bronze/Silver/Gold, Medicare, Medicaid, compensation or other coverage, rejects the patients' claim, or allow only part of the claim, I/we shall be responsible for immediate payment of the balance due, as determined by the physician.
3. **This agreement**. I/we have read and understood this agreement, and have received a copy as well.

_____
Name of Patient

_____
Name of Person Guaranteeing Payment

_____
Signature of Person Guaranteeing Payment

Witness/Staff _____