

*Place Patient
Addressograph Label
HERE*

PROMISE TO PAY

Assignment of Benefits: I hereby assign to the Lompoc Healthcare District (Hospital), including independent hospital- based physicians contracting with the District (Physicians), all benefits that are due or may become due to me or my dependents under my insurance plan, and I authorize my insurance company to make payment directly to the Hospital and/or its Physicians.

Important Patient Information: I understand that the Hospital and Physicians cannot guarantee any particular insurance coverage. I should contact my insurance agent or employer for information about any necessary pre- certification, second opinions, exclusions, pre- existing clauses, or other requirements or condition of coverage. It is important that I do so without delay, rather than waiting until I have left the Hospital.

Promise to Pay: I understand that the Hospital and /or the Physicians submit claims to insurance carriers as a courtesy to patients and that I am responsible for the balanced owed. I will make every effort to actively assist the Hospital and/or the Physicians in securing payment for services rendered for which I am liable.

If this account has not been paid in full within thirty days or if other payment arrangements satisfactory to the Hospital and/or the Physicians have not been made, this arrangement to pay may, at the option of the Hospital and/or the Physicians, be declared to be in default and all balances shall become immediately due and payable.

I further understand that this amount is due and payable even though insurance claims may have been made, payment delayed or coverage denied. The Hospital and/or the Physicians do not act on behalf of any insurance plan, policy or company and shall not be limited to benefits paid by insurance.

Upon default, I agree to pay the cost of collection and reasonable attorney's fees incurred in enforcing this contract.

I understand that the Hospital and/or the Physicians expect payment in full and are not required to accept periodic payments.

If you cannot comply with the terms of this guarantee of payment or have any questions, then you must contact the Patient Accounting Office of the Lompoc Healthcare District at (805) 737- 3300 or 508 East Hickory, Lompoc, CA 93436.

X _____
Patient Signature

Witness

Responsible Party if Patient is a Minor,
Or Unable to Sign

Date