NAME ______________________________________ HISTORY NO. ____________________________________

Date of Admission _____________________________ Room and Bed Number _____________________________

NewYork-Presbyterian Hospital
International Services

NewYork-Presbyterian Hospital
Columbia University Medical Center
177 Fort Washington Avenue, MHB-9 Central
New York, NY 10032 USA
Phone: +1 (212) 305-4900
Fax: +1 (212) 342-5393

NewYork-Presbyterian Hospital
Weill Cornell Medical Center
525 East 68th Street, GP1-503
New York, New York 10065 USA
Phone: +1 (212) 746-4455
Fax: +1 (212) 746-4777

FINANCIAL AGREEMENT AND GUARANTEE OF ACCOUNT

1. **Guarantee of Payment.** In consideration of services rendered to the above patient at NewYork-Presbyterian Hospital, I (we) guarantee payment of all charges due to NewYork-Presbyterian Hospital and/or the Physicians of Columbia and Weill Cornell as a result of the patient's hospitalization.

2. **Obligation of Guarantor.** I (we) may be called upon to make payment to NewYork-Presbyterian Hospital, according to this Agreement, as a result of any of the following reasons why payment is not made by the patient or some other third party (and it is acknowledged that this list does not cover every possible reason):

   (a) The patient is unable to pay his bill.

   (b) The patient has no insurance coverage.

   (c) The patient is not eligible for insurance coverage claimed.

   (d) The patient's insurance coverage does not satisfy the full cost of hospitalization.

3. **Hospital Charges.** I (we) agree that the charges incurred represent the fair and reasonable value of the services rendered and are in accordance with the posted charges of NewYork-Presbyterian Hospital, which are available on request.

4. **Demand for Payment.** Payment may be demanded at any time, and the failure to demand payment from the patient or his or her representative, or the failure of any third party payor (such as Blue Cross, Medicaid, Medicare, Union Insurance, etc.) to make payment, shall not affect this guarantee or my (our) immediate responsibility for payment.

5. **This Agreement.** I (we) understand the nature and extent of the obligation which I and (we are) assuming under this Agreement. I (we) have read this Agreement, and have received a copy.

______________________________	______________________________
Signature of Patient	Signature of Guarantor
______________________________	______________________________
Date	Date
______________________________	______________________________
Name of Patient (Print)	Relationship to Patient
______________________________	______________________________
Witness (Print)	Witness Signature