Payment Guarantee

To:

Patient:
Date of Injury:

I fully understand that I am directly and fully responsible for all medical/chiropractic services rendered to me and that this agreement is made solely for their protection and in consideration of their office awaiting payment for any unpaid balance owing for services rendered to me. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover.

I agree to promptly notify Dr. Joseph Merlo of any addition of attorney(s) used by me in connection with this accident, and I will instruct my attorney to do the same.

I have been advised that if I do not sign, Dr. Joseph Merlo will not await payment but may request the entire balance immediately due

Please acknowledge your agreement to this request by signing below and returning it to the aforementioned provider within 5 days of receipt.

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Date **Client’s Signature**