Guarantee Agreement

I. Individual's responsibility for non-covered services:

In consideration of services rendered by Dr. Gary Olson D.C., P.C., to the undersigned patient, the undersigned promise(s) to pay to Dr. Gary Olson, any copayment, co-insurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan. In the case of denial or termination of benefits, or in the event I fail to inform you of any changes in my insurance coverage, I, the undersigned, understand that I am responsible for payment in full for services rendered.

In the case of denial from No-Fault, the Workers' Compensation Board, Workers' Compensation carrier or termination of my chiropractic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

I, the undersigned, understand that I am responsible for payment in full for services rendered, in the event that I fail to receive a referral from my primary care physician, when required by my health plan.

It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

II. Assignment of Benefits Proceeds:

I hereby assign to Dr. Gary Olson, D.C., P.C., all monies and/or benefits to which I am entitled from my insurer, No Fault, Workers' Compensation policy, government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records:

I hereby authorize Dr. Gary Olson to release to my insurer, government agencies, or to whomever if financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of precertification/prior approval purposes.

Signature of Patient or Legal Guardian Date