AGREEMENT OF PAYMENT FOR NON-PARTICIPATING PROVIDER AND PERSONAL FINANCIAL GUARANTEE

Patient's Name ____

Insured Name ____

Insurance Company ____

I understand that the doctors at Orthopaedic Care Specialists are not participating providers for my insurance plan. I agree that any insurance checks received by me (or insured/guarantor) for any services rendered, will be endorsed to Orthopaedic Care Specialists and sent within 10 business days.

I authorize Orthopaedic Care Specialists to be paid out of any settlement, judgement or verdict as it is necessary to adequately and completely reimburse provider for all medical treatment provided to me by any physician at Orthopaedic Care Specialists. I understand that I will remain responsible to the extent permissible under Florida law for the full amount of any balance on my account after partial payment from any source, such as, but not limited to PIP carriers, workers' compensation and any other insurance billed by Orthopaedic Care Specialists on behalf of the patient.

I realize that the balance of my medical bills is my responsibility whether or not my insurance company pays and is to be paid in full by me to the extent permissible under Florida law. For any services rendered by Orthopaedic Care Specialists arising out of an accident or event for which I receive any settlement, award or monetary recovery of any kind related to the injuries or conditions for which I am treated by Orthopaedic Care Specialists ("Recovery"), I agree and instruct any claims representative, attorney, adjuster, or insurance company to withhold from the proceeds of any Recovery sufficient funds to pay all outstanding medical charges of Orthopaedic Care Specialists. I understand and agree that I remain personally responsible for the full amount of my entire bill whether or not any Recovery is made. If partial payment is made to Orthopaedic Care Specialists for any Recovery, I agree that I am personally responsible to Orthopaedic Care Specialists for payment of the entire balance remaining on my medical bill after any partial payment from any source, to the extent permissible under Florida law. I agree that this personal financial guarantee and obligation to pay shall be binding upon myself, my heirs, executors, administrators, or personal and legal representatives of mine.

I hereby guarantee payment of all collection charges, including reasonable attorney's fees and court costs incurred in the event that collection action is necessitated due to the default of payment of said charges. If enforcement is necessary, I agree and acknowledge that this agreement shall be governed by the laws of the state of Florida and venue shall be the appropriate court of competent jurisdiction located in Palm Beach County Florida.

Patient/Guarantor Signature ____ Date ___________