Guarantor Signature (if applicable)



PATIENT AGREEMENT

Date

Relationship

PATIENT NAME: GLIARANTOR: CO-PAYMENT \$ PER Primary Bounnes Consum for Treatment I two. the understand, being advised of the needs for home health/equipment as ordered by the patients' physician, do hereby consent to all such treatments, which in the judgment of the patients' physician, (new hereby reflect valing Norming Association of WNY, Inc. and said physician of all responsibility from my (our) advisable for merity child. If I (voc), should decline treatment without the consent of the patients' physician, (new hereby reflect valing Norming Association of WNY, Inc. and said physician of all responsibility from my (our) advisable for merity child. If I (voc), should decline treatment without the consent of the patients' physician (rev) hereby reflect valing Norming Association of WNY, Inc. and said physician of all responsibility from my (our) advisable for merity child. If I (voc), should decline treatment without the consent of the patients' physician (rev) hereby reflect valing Norming Association of WNY, Inc. and said physician of all responsibility from my (our) advisable for merity child. If I (voc), should decline treatment without the consent of the patients' physician and the nation of the patients' physician and the nation of the patients' physician of th	NAME:		ID NUMBER			
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