John R. Pedrotty, Jr., M.D.

ELIGIBILITY GUARANTEE

I, _____, hereby certify that I am eligible for _____
Name of Patient / Member / Guardian — Health Plan

effective _____. I have chosen _____
Date — Medical Group / Provider

to be my Medical Provider.

I understand that if the above is not true or if I am **not eligible** under the terms of my Health Plan Agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted provider.

_____
Signature of Member / Guardian

_____
Subscriber Number / Social Security Number