[Your Name/Company Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Facility Name]
[Department of Billing/Admissions]
[Address Line 1]
[City, State, Zip Code]

RE: Letter of Guarantee for Payment

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number: [ID Number, if known]
Type of Procedure: [e.g., MRI, CT Scan, PET Scan]

To Whom It May Concern,

This letter serves as a formal guarantee of payment for the diagnostic imaging services scheduled for the above-named patient on [Date of Procedure].

[I/Organization Name] hereby assume(s) full financial responsibility for all costs associated with this diagnostic procedure, including but not limited to technical fees and professional radiologist reading fees.

Please invoice [Me/Organization Name] directly at the following address:

[Billing Name/Department]
[Billing Address]
[City, State, Zip Code]

Payment will be issued within [Number] days of receipt of the final invoice. If you require a deposit or pre-authorization code before the procedure, please contact me immediately at [Phone Number].

Sincerely,

[Signature]

[Printed Name]
[Title/Relationship to Patient]