



### UNINSURED PATIENT PAYMENT AGREEMENT

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

U.S. Renal Care has agreed to provide in-center hemodialysis treatments on a cash basis for the above named patient. Mr./Ms. \_\_\_\_\_ does not carry any form of health insurance coverage for dialysis and agrees to pay an all-inclusive rate of \$475.00 per treatment.

I, \_\_\_\_\_ agree to pay USRC Sinajana \$475.00 per treatment. Payment is due prior to receiving treatment.

Payments should be made payable to:

USRC SINAJANA  
PO BOX 748191  
LOS ANGELES, CA 96913

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

Please fax signed form to Insurance Operations Director at 214-736-2723.