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 a rate of $475.00 per treatment.

I, _________________________________ agree to pay USRC Tumon $475.00 per treatment. Payment is due prior to receiving treatment.

Payments should be made payable to:

USRC TUMON
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.