U.S. RENAL CARE

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 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

Card Holder's Name _____ Card Type: _____
Card Holder's Address: _____
_____
_____
Credit Card Number: _____ Security Code: _____
Expiration Date: _____ (3-digit code on back of card)
Card Holder's Signature: _____ Date: _____

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