FREDERICKSBURG NEPHROLOGY ASSOCIATES, INC.

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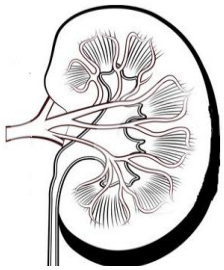

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Fredericksburg, VA 22408
Phone – 540-898-4056 Fax – 540-898-2956

Self Pay Agreement Form

Patient Name:_____ Patient Date of Birth_____

Welcome to Fredericksburg Nephrology Associates, where our professional staff is committed to providing you with the highest quality medical services. We are committed to the success of your medical treatment and care. FNA also wishes to provide patients with a clear understanding of payment expectations. Please contact the FNA Billing Department with any questions you may have.

The following is a statement of our Self-Pay Financial Policy, which we require you to read and sign prior to receiving treatment.

Patient Responsibilities:

- As a self-pay patient, you will be charged a fee depending on the complexity of your visit. Self-pay patients will be informed of the approximate cost of the visit on the day they schedule an appointment.
- Payment for all services rendered at our offices shall be the responsibility of the patient, and are due at the time of service. Appointments will be rescheduled if you are unable to make payment at the time services are to be rendered.
- The patient is responsible for any remaining balance on their account. Please contact the Billing Department if you have any questions.
- All balances must be paid in full prior to any follow-up-appointments.
- FNA accepts cash, check, money order or MasterCard/Visa. Payments can be paid in person, by mail or by phone.
- Accounts that remain unpaid over 90 days may be referred to a collection agency.

Authorization and Release

I have read and fully understand the Self-Pay Financial Form as outlined above. In the event it is necessary to turn my account over to collections, I have been made aware that I am completely responsible for any and all costs associated with the collections process.
By signing this form, I understand I am financially liable for all services provided to me, my dependents or any other person for which I have assumed responsibility for.

_____ _____
Printed Patient/Responsible Party Name Patient/Responsible Party Signature

_____
Date