

ELITE DIALYSIS LLC

AGREEMENT TO PAY

Dialysis Center: Elite Dialysis LLC

Dialysis Center Address: 8201 N. University Drive, Tamarac, FL 33321

Patient Name: _____

MR #: _____

I agree that I will assist the Dialysis Center identified above as needed to collect insurance proceeds from my insurance company or companies (“Insurers”) for services provided by the Dialysis Center to the Patient named above.

I will request that my Insurers pay the Dialysis Center directly, and if direct payment from my Insurers to the Dialysis Center is not an option, I agree to collect payment from the Insurers and promptly deliver such payments to the Dialysis Center. I will endorse any checks I receive from my Insurers for services provided to the Patient named above by the Dialysis Center and deliver them to the Dialysis Center within three days after I receive any such checks. I agree that if I fail to forward any such funds as described above, I will be individually responsible to the Dialysis Center for the amounts paid by Insurers for services provided by the Dialysis Center to the Patient named above.

I understand that failure to forward to the Dialysis Center as described above any funds received from Insurers may constitute a breach of contract and/or fraud and will allow the Dialysis Center to seek legal recourse against me, including reasonable attorney fees and court costs, by filing a legal complaint against me in any court with jurisdiction, and filing liens against assets and garnishing wages of responsible parties to the extent permitted under applicable law.

Signature of Patient or Legal Representative: X _____

Signature of Subscriber of policy if not the Patient: _____

Date: _____