Triangle Kidney Associates P.L.L.C
Service Coverage and Payment Agreement

I _____ hereby authorize Triangle Kidney Associates to perform medical and laboratory services.

I also give that all my insurance benefits are hereby assigned to Triangle Kidney Associates. Any Portion of the bill unpaid is my responsibility.

I understand,

- Deductibles, outstanding balance, and out of network payments are to be paid at the time of check-in.
- Any fees or costs not paid at the time of service within 14 days of receipt of bill.
- Any bill unpaid after 30 days will be subject to bear interest at the highest rate authorized by law in the state of North Carolina.
- All returned checks will be charged a fee of $25.00.
- Any services not covered by the insurance company are my responsibility.
- Prescriptions and refills take 24 hours to process.
- Doctors may return calls up to 24 hours.

I have carefully read the above statement and am in complete understanding of them.

_____ _____

Patient's Signature (Parent in minor). Date