Fox Chase Cancer Center
333 Cottman Avenue
Philadelphia, PA 19111-2497

Financial Services
Tel (215) 728-2678
Fax (215) 214-1539

ATTACHMENT B
PATIENT FINANCIAL AGREEMENT

Date: _____

PATIENT NAME _____ DOB _____

SOCIAL SECURITY # _____ PHONE #_____

GUARANTOR NAME _____

ADDRESS _____

CITY, STATE _____

ADMISSION/SERVICE DATE _____

TYPE OF SERVICE _____

ACCOUNT NUMBER _____

I, _____agree to pay Fox Chase Cancer Center the of _____sum for the above services.

I UNDERSTAND THAT THE AMOUNT QUOTED FOR THIS SERVICE IS ONY AN ESTIMATE, I WILL BE RESPONSIBLE FOR ANY ADDITIONAL TESTS AND/OR PROCEDURES THAT ARE PERFORMED. I ALSO UNDERSTAND THAT THE AMOUNT QUOTED IS FOR HOSPITAL CHARGES ONLY. ALL PHYSICIAN AND ANCELLARY CHARGES ARE EXCLUDED FROM THIS AGREEMENT.

PAYMENTS WILL BE MADE AS FOLLOWS

_____

_____

_____

I UNDERSTAND THAT IF I DEFAULT IN THIS AGREEMENT, ANY DISCOUNTS THAT MAY HAVE BEEN OFFERED WILL BE FORFEITED AND I WILL BE RESPONSIBLE FOR FULL CHARGES. I ALSO UNDERSTAND THAT FAILURE TO PAY THIS BILL MAY RESILT IN MY ACCOUNT BEING TURNED OVER TO A COLLECTION AGENCY.

SIGNED **X**_____

(PATIENT/GUARANTOR) DATE

SIGNED _____

(FOX CHASE CANCER CENTER REPRESENTATIVE) DATE