MARINE PARK RADIOLOGY, P.C.
2270 KIMBALL STREET, SUITE 102
BROOKLYN, NY 11234

AGREEMENT FOR PAYMENT

Patient Name_____(the "Patient")

In consideration of the radiology services to be provided to the Patient by MARINE PARK RADIOLOGY, P.C. (the "Provider").

1.   I,_____, understand and agree that I am fully and totally responsible for all charges submitted or billed for radiology services provided to the Patient and to the extent that my insurance company does not pay for such services (including any copayment, deductible, coinsurance or other fees required by my insurer), I shall pay such charges or bill in accordance with the Provider's payment policies.

2.   I understand that it is my responsibility to be aware of the specifics of my insurance plan and the portions of billed services for which I am personally responsible.

3.   I understand and agree to pay copayments at the time of service and deductibles or contractual co-insurance amounts when such balances are due.

4.   I agree to promptly inform MARINE PARK RADIOLOGY, P.C. of any changes in my insurance plan to allow accurate billing for services. I further understand that if I have not correctly given the Provider accurate and current information regarding my insurer or other health benefit plan, I will be personally responsible for the cost of all care provided by the Provider.

5.   I understand that if I fail to pay my bill or charges noted herein, my account may be sent to collections or credit bureau reporting agencies and I agree that, if requested, I will pay a fee equal to 25% of the balance. This is to cover the cost of the collection agency. I may also be subject to additional fees and interest if the account is turned over to an attorney for litigation (in addition to the amount outstanding on my account).

Current Co-Payment amount (if applicable) $_____

I, _____ have read the above Agreement for Payment and the Agreement for Co-Payment and understand my responsibilities inherent in each.

Date:_____

Signature:_____

Print Name:_____