RED ROCK MEDICAL GROUP

R.D. Prabhu, M.D

President

COLLECTION POLICY

Patient Name: _____

I, hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

Returned checks: A $25.00 NSF fee will be charged for checks initially returned to the bank. If the check is returned unpaid a second time, it may be referred to a co11ectioii for recovery.

_____ _____

Signature Patient or Responsible Party Date

_____ _____

Signature of Witness Date

5701 W. Charleston, #100 • Las Vegas, Nevada 89146

(702) 877-9514 • Fax: (702) 877-0399