NovaCure CONSULTANTS, PC

8101 Hinson Farm road, Suite 211, Alexandria, VA, 22306 . Ph: 703-780-2216 . F: 703-780-9487

Hematology & Oncology Specialists

Financial Responsibility Agreement

I hereby acknowledge that I am responsible for the cost of any and all services provided to me by the office of Dr. Soren Caffey (*N*ova*C*ure *C*onsultants, pc). I understand that I will be financially responsible for the cost of any services not covered by my insurance(s). I understand that I am responsible for the cost remainder if any services or charges are only partially covered by my insurance(s). I agree to verify all benefits with my insurance(s). I understand that I am responsible for all copayments and deductibles and coinsurances and for the payment of any non-covered services.

I hereby acknowledge that the contract I have with my insurance company (ies) is my individual responsibility. If I change my insurance coverage, I am responsible for notifying *N*ova*C*ure *C*onsultants of such change(s) prior to the effective date of the change(s). I will be held responsible for any cost incurred by my failure to do so.

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible. **Balances due that are greater than $500 and remain unpaid for more than 30days after the monthly statement date will accrue interest at a rate of 18% APR. Any balance that remains unpaid for more than 6 months may be subject to collections agency action.** In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs.

Any balances greater than $500 must be paid in full by December 31st of each calendar year. Failure to comply with office financial policy may result in interruption of treatment at NovaCure.

The undersigned certifies that he or she has read this form and understands its terms. The undersigned certifies that he/she may request a copy of it and that the undersigned is either the patient or is duly authorized to sign this form and accept its terms.

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Patient (Guardian/Responsible Party)

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Date