This Consumer Credit Agreement provides detailed information about the financing program available through Morehead Memorial Hospital.

If you would like to finance a balance with us, please complete and sign both forms. Keep one for your records and mail the other back to the hospital at:

Morehead Memorial Hospital
Patient Accounting
117 East Kings Highway
Eden NC 27288-5299

If you have additional questions about the program, please call us at 336/627-6195.
CONSUMER CREDIT AGREEMENT

WHEREAS, Morehead Memorial Hospital (hereinafter, the “hospital” or “we” or “us”) has provided, and may provide in the future, services to the above-referenced patient; and

WHEREAS, each person who signs this Consumer Credit Agreement (hereinafter, the “Agreement”) as a Responsible Party agrees to be financially responsible for the payment of all charges for the patient and desires for the Hospital to extend credit for the payment of these charges; and

WHEREAS, the Hospital is willing to extend credit only upon the terms of this Agreement, as stated on this page and the additional terms on the back of this Agreement;

NOW, THEREFORE, FOR VALUE RECEIVED each Responsible Party (hereinafter collectively referred to as “you”) promises to pay to the order of the Hospital all amounts owing under this Agreement.

FINANCE CHARGES. You agree to pay a FINANCE CHARGE, which is the dollar amount which will be added to your account each month in exchange for allowing you to pay only a portion of your charges. The monthly periodic rate for this account is 1.25%, which is the equivalent to an ANNUAL PERCENTAGE RATE of 15%.

<table>
<thead>
<tr>
<th>Annual Percentage Rate</th>
<th>Grace Period</th>
<th>Balance Calculation Method</th>
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<tbody>
<tr>
<td>1.25 % per month or 15%</td>
<td>60 days from discharge if uninsured and if insurance 60 days from final payment by insurer.</td>
<td>Average daily balance which will include any new services</td>
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MINIMUM MONTHLY PAYMENT. The Minimum Monthly Payment will be 7.5% of the balance due rounded to the nearest dollar amount, but not less than $75.00. Your minimum Monthly Payment will not decrease until the account is paid in full.

OTHER CHARGES. If you pay this account by check and your bank returns your check unpaid, you agree that we may add a $20.00 returned check fee. If any payment is past due for ten (10) days or more, a late charge of five percent (5%) of the amount of the past due payment or $6.00 (whichever is less) will be charged to your account. A late charge may be charged only one time for each late payment.

NOTICE
ANY HOLDER OF THIS CONSUMER CREDIT AGREEMENT IS SUBJECT TO ALL CLAIMS AND DEFENSES WHICH THE DEBTOR COULD ASSERT AGAINST THE HOSPITAL PURSUANT HERETO OR WITH THE PROCEEDS HEREOF. RECOVERY HEREUNDER BY DEBTOR SHALL NOT EXCEED AMOUNTS PAID BY DEBTOR HEREUNDER.

By signing below, you unconditionally promise to make prompt payments when due of any amounts owing under this Agreement. You agree to pay all amounts owing hereunder without requiring any holder of this Agreement to first bring suit or take another action against any other person. You waive notice of acceptance, presentment, dishonor, and notice of dishonor. The payment obligations hereunder are joint and several.

IN WITNESS WHEREOF, the undersigned have hereunto set their hands and seals.

RESPONSIBLE PARTY NO. 1:  RESPONSIBLE PARTY NO. 2:

(Print Name) (Date)  (Print Name) (Date)
(Seal)  (Seal)
(Signature)  (Signature)
(Social Security Number)  (Social Security Number)

Hospital Copy
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IN WITNESS WHEREOF, the undersigned have hereunto set their hands and seals.

RESPONSIBLE PARTY NO. 1:  
(Print Name)  
(Date)  
(Signature)  
(Social Security Number)

RESPONSIBLE PARTY NO. 2:  
(Print Name)  
(Date)  
(Signature)  
(Social Security Number)

Patient Copy
BILLING STATEMENT. When there is a balance on this account, we will periodically send you a billing statement. Each statement will show the total amount you owe (the “New Balance”), the smallest amount you have agreed to pay (the “Minimum Monthly Payment”), and the date by which we must receive your Minimum Monthly Payment. Billing statements and any other notices will be sent to you at the patient’s address on record, unless you notify us otherwise. If you move, you must tell us your new address right away.

DEFAULT. If payment is not received when due, or if you default in any obligation contained herein or in any other obligation to us, then this Agreement, at our options, shall be deemed in default. Upon default, we may declare all sums due hereunder or under any other obligation by you to us immediately due and payable. We shall also have any and all other rights and remedies provided by law. If you default, you agree to pay our costs of collections, including reasonable attorney fees. You agree that the Annual Percentage Rate shall apply, to the extent allowed by law, to the amount of any judgment we obtain for the collection of payment under this Agreement.

ASSIGNMENT. We may assign all of our rights and obligations under this Agreement to Revenue Cycle Solutions Group, or any other person or entity. Your rights and obligations are not assignable.

MISCELLANEOUS PROVISIONS. You agree that we may check information about you with a credit bureau or other reporting entity, and we may also report information about how you have handled your accounts to another entity as allowed by law. We may accept late or partial payments on any occasion without losing any right under this Agreement. This Agreement shall be governed by the laws of North Carolina, and you agree to exclusive jurisdiction in the state courts of North Carolina. This Agreement contains the entire understanding of the parties, and no other agreement or understanding exists apart from this Agreement. If any part of this Agreement is held unlawful, invalid, or unenforceable by a court of competent jurisdiction, such provision shall be severed herefrom and the balance of the Agreement will remain in full force and effect to the fullest extent allowed by law.

YOUR BILLING RIGHTS

KEEP THIS NOTICE FOR FUTURE USE

This notice contain important information about your rights and our responsibilities under the Fair Credit Billing Act.

NOTIFY US IN CASE OF ERRORS OR QUESTIONS ABOUT YOUR BILL

If you think your bill is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address listed on your bill. Write to us as soon as possible. We must hear from you no later than sixty (60) days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter give us the following information:

- Your name and account number
- The dollar amount of the suspected error
- Describe the error and explain, if you can, why you believe there is an error.
- If you need more information, describe the item you are not sure about

YOUR RIGHTS AND OUR RESPONSIBILITIES AFTER WE RECEIVE YOUR WRITTEN NOTICE

We must acknowledge your letter within thirty (30) days, unless we have corrected the error by then. Within ninety (90) days, we must either correct the error or explain why the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.

If we find that we made an error on your bill, you will not have to pay any finance charges related to any questioned amount. If we did not make a mistake, you may have to pay finance charges, and you will have to make any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date that it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you and you write to use within ten (10) days telling us you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And, we must tell you the name of anyone we reported you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we do not follow these rules, we cannot collect the first $50.00 of the questioned amount, even if your bill was correct.