Exhibit 2

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

Self Pay Outpatient/Non-SDC Patient
Payment Agreement Form

(Please print when completing this form)

Today's Date: _____ Clinic Contact Name: _____

Outpatient Visit Location:_____ Phone: _____
(as entered in SDK location, e.g. H ORTHOPEDIC CLINIC, OR E REHAB MED O/P)

Patient First and Last name: _____MRN: _____

Anticipated Date of Service: _____ Office Visit/Consultation CPT:_____

Patient's Address: _____

Payer's Name: _____

Payer's Address: _____

To be completed by Patient Financial Services
☐ Patient elects to pay total incurred charges within 30 days with 40% discount 50% down payment based on estimated charges with 40% discount = $ _____ has been paid; this down payment will be applied to the actual incurred charges.
☐ Patient elects no discount, total incurred charges will be paid within one year 50% down payment = $_____ has been paid, this down payment will be applied to the actual incurred charges.

Exclusions:

- Boston Medical Center Facility Fees **do not include** professional services. Professional services are billed separately.
- Boston Medical Center facility Fees **do not include:** 1) Pharmaceuticals obtained from retail pharmacies or from Medical Boston's hospital based pharmacy (for drugs typically obtained at retail pharmacies, 2) Home care services, and 3) Durable medical equipment.

Please make payments in U.S. Dollars by check, or credit card, or money order. Please mail or deliver payment along with this signed letter.

Boston Medical Center
Attention: Patient Financial Services, Customer Service
85 East Concord Street, Ground Floor
Boston, MA 02118

Agreed:
Payer or Patient's Signature: _____ Date:_____

Agreed:
BMC PFS Signature: _____ Date:_____