Mosaic Finance Solutions, Inc.

CONSUMER CREDIT AGREEMENT

This agreement explains how your health care institution open-end account will work. It also explains the terms that both you and we agree to follow for these accounts. In this Agreement, "we", "us" and "our" mean the health care institution. "You" and "your" mean any who signs this Agreement. By signing this Agreement, you agree to do what the Agreement says.

PROMISE TO PAY You promise to pay to us the total amount financed under this Agreement, plus interest at the Annual Percentage Rate stated below, in accordance with the terms set forth in this Agreement. In the event you incur additional charges with the Health System, we may add these amounts to this account.

MONTHLY STATEMENT – When you have a balance on your account, we will send you a billing statement each month. The statement will show the amount you owe us, which is called the New Balance. The statement will also show the smallest amount you have agreed to pay us, which is called the Minimum Monthly Payment Due.

PAYMENT AGREEMENT - Your payments will be used first to pay finance charges and then to pay any remaining balances. You may, at any time, pay the account balance in full. **NOTE**: If you pay your principal account balance in full within thirty (30) days, we will waive the interest charges. The thirty (30) day period starts on the date listed on the acknowledgement letter you receive from Mosaic Finance. No other free period is allowed.

NO ANNUAL FEE – is charged for this account.

MINIMUM MONTHLY PAYMENT DUE – The Minimum Monthly Payment Due will be 2.5% of the new balance rounded to the nearest dollar amount, but not less than $25.00 (or the new full balance if less than $25.00). The minimum payment will be increased by any returned check charge, late charge and any past due amount. You may at any time pay more than the minimum payment or your balance in full. Your minimum payment will not decrease until the New Balance is paid in full.

TRUTH IN LENDING DISCLOSURE

FINANCE CHARGE – **A FINANCE CHARGE** is the amount we will add to your account for allowing you to pay us for only part of your charges each month. A **FINANCE CHARGE** will be added to the daily principal balance, unless your account has a zero balance at the end of the day. The **FINANCE CHARGE** is based on an **ANNUAL PERCENTAGE RATE OF** ***5.25*** **%,** which will be applied to your Daily Balance. We will add a **FINANCE CHARGE** on new charges billed to your account, starting with the day they were first billed to your account.

By signing below, I admit that I have read and agree with the terms of the Agreement. I have been provided a copy for my records.

Today's date	Health care institution Account Number(s)
Patient/Responsible Party	Health care institution/Department
SS #	By: Health care institution representative

PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION

OTHER CHARGES – If you pay your account by check, and the bank returns your check unpaid, you agree that we may add a $25.00 "return check" fee to your account as permitted by law. If any payment is past due for ten days or more, a late charge of $10.00 (ten dollars) will be charged to your account.

OVERPAYMENTS – I understand in the event of any overpayments accepted by the finance company, those amounts shall be refunded back to the original creditor to be applied to any other outstanding balances for which I am responsible, or returned to me if there is no outstanding balance with original creditor for which I am responsible.

OUR RIGHTS – If this is a joint account, each of you will be jointly and individually responsible for payment of all charges for goods and services provided to you, your spouse, or children. If we commence a lawsuit to collect your account(s), you must pay to us all costs and expenses of collection that we incur, including our reasonable attorney's fees. We may limit or cancel your account(s). If you do not pay on time, we can require that you make immediate payment of the total amount that you owe us.

ASSIGNMENT OF ACCOUNT – Your health care institution account will be assigned to Mosaic Finance Solutions, Inc., and that company will receive your payments and service your account.

YOUR ADDRESS – If you move, you must tell us your new address right away. Billing statements and any other notices to you will be mailed to the patient's address given to the admission staff of the health care institution, unless you notify us otherwise

YOUR BILLING RIGHTS.
KEEP THIS NOTICE FOR FUTURE USE.

This notice contains 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 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 us within ten 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 report 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 of the questioned amount, even if your bill was correct.

MOSAIC FINANCE SOLUTIONS, INC.

PO BOX 26152

GREENSBORO, NC 27402

TOLL FREE: 1-866-869-8552

Mosaic Finance Solutions, Inc.
PO Box 26152
Greensboro, NC 27402
336-889-0929
Toll Free: 1-866-869-8552

The person signing the Consumer Credit is taking responsibility for payments on this account.

Please complete the information listed below.

Patient Name:_____

Patient/Hospital account: (s) _____ _____

_____ _____

Your Name: _____

Male _____ Female _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: ( ) _____

Social Security #:_____

Birth Date: _____

Employer: _____

Please return this form with the signed Consumer Credit Agreement.