

**EMMA SMITH**  
**HOUSTON , TEXAS , UNITED**  
**STATES // N/A MRN: 0808398**

Thank you for choosing The University of Texas M. D. Anderson Cancer Center for your health care needs.

We realize that this is a difficult time for you and your family, and finances may be an additional concern. We are committed to supporting you by providing an estimate of charges. This Charge Estimate is based on a plan of care that your physician has recommended for you at this time. Your actual charges may be more or less than the estimated amount. Your physician may decide to order additional tests or procedures, which may result in more charges.

If you are sponsored by an embassy or have insurance, M. D. Anderson will bill your embassy or insurance. Contact your insurance plan for specific coverage information that may impact your financial responsibility. For services not covered by your insurance, or if you do not have coverage, payment is requested prior to receiving care.

You will receive a statement of total charges approximately four to six weeks after your appointment. If your total charges are more than the estimate you paid, M. D. Anderson will bill you for the balance. If your actual charges are less than the amount you paid, you will receive a refund. If there is any delay in starting your plan of care, or if your plan of care changes, please contact your Patient Access Specialist to obtain an updated Charge Estimate.

M. D. Anderson is committed to providing you exceptional care and services. For additional information or assistance, please contact your Patient Access Specialist Librada Solis at 713/792-5424.

<b>Treatment Plan Charges    DRAFT</b>				
<b>Description</b>	<b>Type</b>	<b>Quantity</b>	<b>Unit Charge</b>	<b>Total Charge</b>
CLINICAL STUDY OUT PATIENT FACILITY	Hospital	1	\$29,973	\$29,973
CLINICAL STUDY- DRS	Physician	1	\$19,983	\$19,983
POST STUDY TREATMENT OUT PATIENT FACILITY	Hospital	1	\$11,711	\$11,711
POST STUDY TREATMENT- DRS	Physician	1	\$7,806	\$7,806
PRE TREATMENT CLINICAL STUDY OUT PATIENT FACILITY	Hospital	1	\$11,880	\$11,880
PRE TREATMENT CLINICAL STUDY- DRS	Physician	1	\$7,920	\$7,920
<b>SUBTOTAL</b>				<b>\$89,273</b>

<b>SUMMARY OF CHARGES    DRAFT</b>	<b>TOTALS</b>
<b>TOTAL HOSPITAL CHARGES</b>	<b>\$53,564</b>
<b>TOTAL PHYSICIAN CHARGES</b>	<b>\$35,709</b>
<b>SUBTOTAL</b>	<b>\$89,273</b>
<b>DISCOUNT - 0%</b>	<b>\$ 0</b>

<b>ADJUSTMENTS</b>	<b>\$ 0</b>
<b>TOTAL</b>	<b>\$89,273</b>

I acknowledge receipt of this estimate:

\_\_\_\_\_  
Patient/Guarantor Signature

\_\_\_\_\_  
Date