



Virginia Cardiovascular Specialists

Assignment of Benefits and Payment Agreement and Authorization to Release Information

I hereby authorize Virginia Cardiovascular Specialists, P.C. (VCS) to furnish to my insurance carrier(s), attorney, or legal representative all information which said parties may request concerning my illness or injury. I hereby assign to VCS all benefits payable by my insurance company and/or third party payor for services received by me until the amounts owed, including interest and attorney fees, are paid in full. I further agree and accept as follows:

My insurance policy is a contract between me and my insurance carrier. I recognize that I am personally responsible to VCS for ALL charges for services rendered plus interest that will accrue on the outstanding balance at the rate of 1 ½ percent per month (18 % per annum).

I recognize that VCS will bill and collect from my insurance carrier as a courtesy to me. I will be informed as to any balance due from me VCS. I fully understand that VCS may not accept the amount as insurance carrier states as their "usual & customary fees" (UCR) as payment in full. This may lead to my getting a bill for deductibles, co-payments, and co-insurance. Regardless of my insurance, I will probably have a balance due for services rendered. I agree to pay for any such balance. For those policies that require pre-authorization or referrals, this must be completed prior to seeing any physician. It is my responsibility to obtain all necessary referrals from other physicians, as required by my insurance carrier. I am responsible for understanding my individual insurance policy and benefits prior to seeking services. I will ask for help if my insurance is not clear to me.

Although I may be represented by an attorney on matters related to the illness or injury for which VCS has rendered services to me, I must still keep my account paid in full.

If my account becomes delinquent and is referred to an attorney or agency for collection, I agree to pay 33 1/3 percent of attorney fees and all court costs incurred by VCS, in addition to the outstanding balance of the account.

I fully understand that while VCS is willing to send an insurance claim to my insurance carrier, this is done as a courtesy, and VCS will not be responsible for lost claims or claims that do not arrive at my insurance carrier. Patients are encouraged to remain in touch with their insurance carrier as to the status of the claim. I understand that if payment from my insurance carrier is not received by VCS within 75 days from the date of service, the TOTAL balance will become my responsibility and will be due immediately. All accounts that are 90 days old will be sent to collections.

This agreement is in addition to any other agreement which I may have with VCS. I have read this document, understand it fully, and agree to the terms and conditions.

Signature

Date