FAIRFAX LUNG CENTER

FINANCIAL ASSIGNMENT AND AGREEMENT

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**

2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should my account be turned over to an attorney for collection I will be responsible for attorney fees in the amount of 35% of the principle amount owed and interest in the amount of 24% per annum from the last date of service, compounded monthly. I hereby authorize said assignee to release all information necessary to secure the payment.

4. We reserve the right to charge a $100.00 fee for a missed appointment when you fail to give our office 24 hours notice.

5. There will be a processing fee for copying medical records, special dictated reports, and forms for employers, licensing agencies, government agencies, etc.

6. It is your responsibility to determine if a referral is needed prior to the office visit. If your insurance plan requires a referral and you do not have a referral with you at the time of your visit we must reschedule your visit or you can pay all of your fees at the time of service. You agree to pay for services rendered if you do not have a valid referral at time of appointment.

Signed (Patient or parent if minor) _____ Date _____