Colonial Internal Medicine Associates, PC

125 Olde Greenwich Drive Suite 300-Fredericksburg, VA 22408

392 Garrisonville Road-Suite 106-Stafford, VA 22554

Office-540--374-5599

TO ALL PATIENTS:

We ask that all patients pay their office visits at the time of service, unless you have made prior arrangements through a payment plan agreement.

PATIENTS WITH INSURANCE COVERAGE:

If you have provided complete and legible insurance information your insurance will be billed for you. This in no way relieves you of your financial responsibility of your medical claims. If your insurance plan requires a co-payment, it will be due at the time of your visit. If you do not want us to file your claims to your insurance, please let us know. I hereby assign, transfer and set over to the physicians of Colonial Internal Medicine Associates, PC all of my rights, title and interest in and to medical reimbursement and/or payment for medical services provided by the physicians of Colonial Internal Medicine Associates, PC.

WORKMAN'S COMPENSATION OF AUTOMOBILE ACCIDENT PATIENTS:

We do not participate with any workman compensation or automobile accident carries including third party liability. We will release your personal medical information upon your written authorization including itemization of charges and office notes upon request. You will be responsible for any charges related to the above in a timely manner

FINANCIAL POLICY FOR PATIENTS UTILING INSURNACE:

In Consideration for the professional services rendered no and in the future, the undersigned hereby agrees to pay 18% interest per annum on all balances which are unpaid sixty (60) days after the services are rendered; plus attorney's fees which are hereby stipulated to bee 1/3% of such outstanding balance whether suit if filed or not; plus court costs. If the undersigned fails to pay promptly for the services rendered, the undersigned authorizes the release by or to any credit reporting agencies of personal credit information on the undersigned and further agrees to pay all costs of obtaining credit information and/or location the undersigned as may be necessary.

The undersigned understands that Medical Insurance claims may be billed by the provider as a courtesy, if the provider participates with the patient's insurance plan, and if the patient promptly furnishes the provider with all correct insurance information. The undersigned is fully responsible for all sums due whether or not insurance coverage is available. In the event prompt payment is not made by the undersigned, the undersigned understands that personal and financial records concerning these professional services will be released to the provider's attorney for collection. The attorney will act as the provider's "Business Associate" in compliance with federal "HIPAA" regulations.

MEDICARE PATIENTS:

I authorize the holder of medical or other information about me to release to the Social Security Administration of the intermediaries or carriers any information for all Medicare claims. I assign the benefits payable for covered services to Colonial Internal Medicine Associates, PC and or its physicians.

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Signature of Patient or Responsible Party **Date**