

VIRGINIA ORTHOPAEDIC CENTER, P.C.

CREDIT POLICY

In the interest of good medical/surgical practice, it is desirable to establish a credit policy. An effective credit policy enables the doctor and patient to avoid misunderstandings. Our primary responsibility is to help our patients experience good health care. We wish to spend our time and energy practicing medicine.

Since billing costs are expensive, charges for office services are payable on the day they are rendered. For your convenience payment can be made by cash, check, Visa or Mastercard. We may extend special consideration by accepting payment over an extended period of time if these arrangements are made in advance with the office.

We will process your primary insurance. Please inform the receptionist if you were injured on the job. Your workman's compensation claim will be filed. If the claim is denied as workman's compensation, you will be responsible.

Statements are mailed monthly for your convenience. Once any account is 120 days old, interest in the amount of 12% per annum will be added every 30 days.

In the event that an account becomes past due (60 days with no payment without reason satisfactory to us), collection procedures are taken. Should your account be placed for collection, you hereby agree to pay all collection costs, including attorney's fees, court costs and interest of 12% per annum on the balance due at that time. Again, our primary responsibility is to help our patients experience good health care and we wish to spend our time and energy practicing medicine.

AGREED / SIGNED _____ (SEAL)

DATE _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the doctor(s) whose name(s) appear(s) below to furnish my insurance company(s), attorney or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign to Virginia Orthopaedic Center, P.C. whose name appears below, all money to which I may be entitled for medical and/or surgical expense relative to the service reported herein, but not to exceed my indebtedness to said clinic. It is understood that any money received from the above-named parties, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand I am financially responsible to said clinic for charges not covered by this assignment. I further agree and understand that if extended credit, I will keep my account on a current basis. It is also understood that even though I may have an attorney, I must still keep my account on a current basis.

SIGNED _____ (SEAL)

Insured/Patient/Guardian

VIRGINIA ORTHOPAEDIC CENTER, P.C.
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