Fredericksburg Nephrology Associates Inc.

101 Park Hill Drive
Fredericksburg, VA 22401
540-371-3010

Pogonia Medical Arts Building
4604 Spotsylvania Parkway Suite#335
Fredericksburg, VA 22408
540-898-4056

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to *Fredericksburg Nephrology Associates Inc*. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize my insurance benefits be paid directly to the physician. I further authorize that the physician may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

FINANCIAL AGREEMENT

I/We agree to be financially responsible to *Fredericksburg Nephrology Associates Inc*. for the remaining balance left by the insurance company (i.e. co-insurance, deductibles & co-pays). The cost of these services shall be in accordance with the fee schedule in effect at the time of service. The undersigned agree(s) to pay, in addition to the doctor's fees, any and all costs of collecting the amount due on that date. I/We acknowledge receipt of a copy of this agreement and fully agree to and understand the condition set forth regardless of any insurance coverage, court litigation, or other party involvement.

THIRD PARTY/WORKER'S COMPENSATION BILLING POLICY

Fredericksburg Nephrology Associates Inc. does not become involved, nor do we file claims in third party liability cases. It is the patient's responsibility to see that the bill is paid promptly, regardless of any pending litigation resulting from an injury caused by a third party. We do not participate with Worker's Compensation.

I understand that my signature below indicates I have also received and read a copy of Fredericksburg Nephrology Associates Office Policy.

_____ _____

Patient Name (please print) Patient Signature

_____ _____

Witness Signature Date