National Vascular Associates
FINANCIAL AGREEMENT & RELEASE OF INFORMATION

AUTHORIZATION FOR TREATMENT

I hereby authorize treatment by National Vascular Associates and/ or affiliated medical staff member(s) on behalf of myself and legal responsibilities, including the patient whom I have medical power of attorney over.
The possibility exist (during treatment) for health care workers to become directly exposed to my blood or bodily fluids. In the event of such exposure, State Law requires a sample of my blood to be tested for the presence of infectious diseases.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or charge information as is necessary for reimbursement from any third party or governmental agency involved in the payment of my treatment including but not limited to Insurance Payers, HMOs, Workers Compensation carriers, Medicare, Tricare and Medicaid. I also authorize the taking and use of photographs. I understand these photos will become a part of my medical record

RELEASE OF MEDICATION HISTORY

I hereby authorize the release of any and all medication history information as is necessary and pertinent for my medical care at National Vascular Associates.

OBLIGATION OF PAYMENT

I direct and assign payment from any insurance coverage, workers compensation, governmental agency or disability benefits, and assignment of proceeds from all settlements, judgments or verdicts in favor of the undersigned from third party liability claims for injuries treated hereunder in an amount equal to the full amount of all charges (including attorney's fees, collection agency fees, cost and interest) due hereunder is to be made to National Vascular Associates. I am responsible to National Vascular Associates for any charges not covered by my insurance, including but not limited to co-payments, deductibles and fees for non-covered services. The patient and the undersigned guarantor are primary liable for payment of the Patient's account and unless otherwise indicated by my initialing here,_____(initials). National Vascular Associates will send all appointment reminders andbilling information to the person responsible for payment of my bill. It is their sole responsibility to comply timely with all requirements, and supply all information and documents necessary to obtain payment of benefits by any third party or government entity as listed above. Some insurance plans (i.e., Medicare, Blue Cross, Champus) require that lab work be billed directly by the laboratory performing the testing. In these instances, a separate statement and bill will be sent from the lab performing the test.

NO SHOW AND CANCELLATION POLICY

We require a 48-hour notice, in advance, to cancel or reschedule any appointment or surgery. All appointments or surgeries that are missed without a call in advance are deemed a "No Show/ No Call" and will incur a $50 fee. This charge is not covered by your insurance and you will be responsible for this payment. This charge is payable at your next appointment.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

Any balance remaining on the account after any insurance pays will be due upon receipt of my statement. Charges for non-covered services are due at the time of service. The undersigned agrees(s) to pay all charges made by medical providers at their current rate. The obligation of each undersigned is an original, direct and independent promise to pay based on the exclusive credit of each, and not a collateral or contingent promise to answer for the debt of another. If a payment is not made, I understand that National Vascular Associates may take action to collect its fees. I agree to pay all costs incurred by National Vascular Associates for collecting its fees, including collection agency and attorney's fee of forty-three percent (43%) of theunpaid bill. The return check fee is $38.00.

*Thank you for selecting **National Vascular Associates** as your Health Care partner.*

*Billing is handled by **Express Billing Systems**. For insurance or billing questions please contact **Express Billing Systems** at **757-410-8967**.*

Patient Name (Please Print): _____

Patient/Legal Guardian Signature:_____Date: _____

Witness:_____Date: _____