AUTHORIZATION TO RELEASE & PAY BENEFITS

Patient's Full Name _____ Date of Birth _____

I hereby consent to treatment by Dr. Abdelshaheed and / or assistant and accept responsibility for fees for such medical services. I understand that treatment may include medical appliances and / or such other procedures deemed necessary.

I understand that payment (or co-payment) is expected at time of services, and my insurance is filed as courtesy to me. I understand that I am financially responsible for charges not paid by my insurance. I further understand that if a balance results on my account at the time of any litigation settlement relating to my account with this practice this will be the first bill paid and paid in full at the time of settlement. Should collections actions become necessary, I understand that I will be liable for any and all costs, including all attorney fees associated in collecting the unpaid balance owing on my account.

I hereby authorize the release of any information necessary for filing of insurance and direct payment to Dr. Abdelshaheed or **FAMILY MEDICINE HEALTH CARE** for any amount due under my present policy or any policy that I may at a later date ask to be filed.

This authorization is valid for current and subsequent treatment unless I submit a written revocation. A photo copy of this authorization shall be considered as valid as the original. I will advise **FAMILY MEDICINE HEALTH CARE** and / or medical staff, of any changes of my insurance coverage. The undersigned agrees to pay all costs of collections including attorneys fees of 331/3% of the amount of the account placed with the attorney.

If I fail to appear for scheduled appointments, it is my responsibility to reschedule, without any expectation from FAMILY MEDICINE HEALTH CARE to call me to determine my failure to appear. In the event that I am unable to give FAMILY MEDICINE HEALTH CARE 24 hours notice of my inability to appear to my appointment I may be charged a $20.00 fee.

If health care workers are exposed to my blood or body fluid in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Insurance is filed as a courtesy. Co-pays are expected at time of service.

Signature of Patient or Responsible Party _____

Relationship to Responsible Party _____ Date _____

Samir Abdelshaheed, MD • 6111 Portsmouth Boulevard • Portsmouth, VA 23701 • office 757-488-3333 • fax 757-488-0007