Authorization & Assignment Agreement

TO: Attorney

_____

_____

Tel: _____

Fax: _____

Records:

FROM: Capitol Rehab of Winchester
230 Costello Drive, Suite 1
Winchester, VA 22602
Tel: (540) 665.4444
Fax: (540) 665.4473

I, _____, hereby authorize Capitol Rehab of Winchester to furnish to the above-named attorney all information provided by or pertaining to me, including all records relating to any health care services rendered by any health care provider under the auspices and/or affiliated with Capitol Rehab of Winchester, for the purpose of recovery from third parties, accident insurance policies and/or health insurance. I authorize and direct my attorney to immediately pay all bills received from Capitol Rehab of Winchester from the proceeds of any recovery on my case as soon as my attorney receives these funds. ____initial

Doctor's/ Clinic's Lien

I agree that I am personally responsible for prompt payment to Capitol Rehab of Winchester, the full amount of all invoices that are issued by Capitol Rehab of Winchester for treatment or services rendered to me for my benefit, that the payments shall not be contingent upon the payment to me of any benefit, insurance, or reimbursement by any other party, and that the lien and direction to pay contained in the preceding paragraph is solely as additional security to Capitol Rehab of Winchester. ____initial

I agree the the proceeds of health and accident insurance policies that are collected will be applied to this debt, and I understand that any resulting overpayment will be refunded to me except in those cases where subrogation of benefits requires my provider at Capitol Rehab of Winchester to refund any overpayments directly to the involved insurance carriers. If a refund is issued to me, I realize that the insurance carriers may still require the overpayment be refunded to them. I agree to pay any and all cost incurred by Capitol Rehab of Winchester, including attorney's fees, in the event I fail to refund the overpayment, and any insurance company or its agent contacts or sues Capitol Rehab of Winchester regarding the overpayment. ____initial

Cost of Collection

I agree that is any amount due and owing to Capitol Rehab of Winchester for treatment or services performed for me is not paid when due, interest, and collection costs, including attorney fees, will be added to the amount due. I hereby also agree to waive the defense of any statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services are rendered. ____initial

Waiver/Revocation

I specifically waive any claim of privilege with respect to the disclosure by Capitol Rehab of Winchester, to the above-named attorney of information provided by or pertaining to me, which I specifically authorize to be disclosed. The patient has the right to revoke further release of information, but any such revocation shall not terminate the patient's financial responsibility or the lien of Capitol Rehab of Winchester. Capitol Rehab of Winchester has no responsibility for use or further disclosure of such information in the hands of the attorney to whom it is hereby released. ____initial

I understand I may speak with my attorney or insurance company prior to signing this agreement. ____initial

Date: _____ Patient Signature: _____

Date of Injury/ Illness: _____ Printed Name: _____

Acknowledgement

I, the undersigned attorney for the patient referred to above, acknowledge receipt of notice of the lien and that Capitol Rehab of Winchester has the right to all collateral sources dues to the nature of this case being motor vehicle accident or any other accident and agree to provide all MED-PAY/PIP claim information to Capitol Rehab of Winchester for collection of payment for giving consideration for services rendered. I further agree to withhold from any payment benefits, accident insurance policies, health insurance or reimbursement, and make payment of any amount as may be due and owing Capitol Rehab of Winchester, for treatment or services of the patient directly to Capitol Rehab of Winchester. I further agree to notify the provider within 30 days for any change in the status of this case, which may preclude payment of these medical charges by me for any reason. I further agree to require any attorney to whom the undersigned refers this case, within or outside the firm, to honor this assignment as a condition of referral. I further agree to furnish current home and work address information, as well as, cell home and work phone numbers about the patient and/or family to aid in the collection of bills.

Date: _____ Attorney's Signature: _____

Please **SIGN, DATE & RETURN** this assignment to the provider's office. The **medical records cannot be released** to you until we have two signatures.

"Notice: automobile accident patients

If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care provider the right to receive some or all of that payment directly from your automobile insurance company.

If you have health insurance and your healthcare provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any copayment, coinsurance, or deductibles to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit.

If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare provider is not in your health insurer's provider network: your health care provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care."

2. Upon receipt of a copy of an AOB form that satisfies the requirements of subdivision D 1 and (i) an explanation of benefits or remittance advice or (ii) a bill, claim form, or documentation from the assignee advising that it has been represented to the assignee that the covered injured person does not have health insurance or is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, a motor vehicle insurer shall pay directly to the health care provider, from any medical expense benefits available to such person under a motor vehicle insurance policy:

a. If the covered injured person is covered under a health care policy, the health care provider is an in-network provider, and the health care provider has submitted its claim to the health insurer for the health care services, the amount of any copayments, coinsurance, or deductibles owed by the injured covered person to the health care provider, as evidenced by an explanation of benefits, remittance advice, or similar documentation provided to the motor vehicle insurer; or

b. If (i) the covered injured person is not covered under a health care policy, (ii) the covered injured person is covered by a self-insured or self-funded employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 which requires medical expense coverage to be primary, or (iii) the health care provider is not an in-network provider, amounts to cover the cost of the health care services provided, in the amount of the usual and customary fee charged in that community for the health care services rendered;

3. A motor vehicle insurer shall in all respects be held harmless for making payments pursuant to subdivision D 2 to a health care provider in accordance with an assignment of benefits that satisfies the requirements of subdivision D 1;

4. A covered injured person shall not be required to assign to any person any medical expense benefits he may have under this section, including any assignment of the proceeds of such coverages;

5. An assignment of medical expense benefits shall be void and unenforceable as against public policy if the assignment does not comply with the requirements of subdivision D 1;

6. Medical expense benefits may not be reduced because of any benefits paid, payable, or provided by any insurance contract providing hospital, medical, surgical, and similar or related benefits, or any subscription contract or health services plan delivered or issued for delivery or providing for the payment of benefits to or on behalf of persons residing in or employed in the Commonwealth, except as authorized by this section; and

7. Nothing in this section shall prohibit the payment of medical expense benefits due to the covered injured person directly to any state or federal assistance program that has provided medical benefits to such injured person when the injury arose out of the ownership, maintenance, or use of any motor vehicle.

Date: _____ Patient Name: _____

Date: _____ Patient Signature: _____

Date: _____ Staff Member: _____

Claim Number: _____

Patient DOB: _____