ALEXANDRIA
FAMILY PRACTICE

1. For Medicare Recipients:
I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Alexandria Family Practice (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:
I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Alexandria Family Practice (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Alexandria Family Practice, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to Alexandria Family Practice (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:

I understand and acknowledge:

- If my insurance carrier or administrator of benefits does not consider any services rendered covered services, or has not authorized these services, they will not pay and I agree to pay for these services.
- **One or more of my physicians may not accept insurance or may be out of network with my health insurance.**
- In the case of out of plan/network physician or services, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:
In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered, and accept the above conditions and terms; and I agree to pay all charges for which I may be legally and/or contractually responsible, including but not limited to health insurance deductibles, co-payments, and non-covered services. **I understand that Alexandria Family Practice, its affiliates, agents (including but not limited to debt collectors) or designees may contact me about outstanding balances through various methods including the use of manual representative outbound calls and voice messages and/or automated dialing services and pre-recorded artificial voice messages, at any telephone number I provide to Alexandria Family Practice.** I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Alexandria Family Practice. I *understand and agree this document will remain in effect for my present outpatient visit and any future outpatient or physician office visits to* Alexandria Family Practice*, unless specifically cancelled in writing by me.* I understand that I will be asked to review and sign this form once per calendar year as long as I remain a patient of Alexandria Family Practice.

_____	_____	_____	_____
Patient/Guardian/etc. (signature)	**Patient/Guardian/etc.** (print name)	Date	Time

_____
Relationship to Patient (if not signed by patient)

_____	_____	_____	_____
Witness (signature)	**Witness** (print name)	Date	Time

Interpreter Information (To be completed by Alexandria Family staff, if applicable):
❑ In person ❑ Telephonic ❑ Video Interpreter name/ID number (if applicable) _____
❑ Patient/Designated Decision Maker was offered and refused interpreter ❑ Waiver signed

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