Falls Church Healthcare Center
900 South Washington Street, Suite 300
Falls Church Virginia 22046
April 2020
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FCHC@fallschurchhealthcare.com

INSURANCE PARTICIPATION AND AUTHORIZATION AGREEMENT

Using my Insurance: Falls Church Healthcare Center (FCHC), as a service for you, will file your claim for payment of your medical care with your listed Insurance Carrier. Although we rely on your insurance company's good faith pre-authorizations, verifications, certifications and coverage approvals and their reported co-pay, co-insurance and deductible amounts the claim may still be denied by your insurance company or some services not covered once FCHC files your claim. Your insurance plan is a contract between you and your insurance company. We must hold you responsible for any balances due. If your policy includes a co-insurance, a co-pay or deductible amount, that is determined by your insurance company and collected by FCHC at the time of service. If our office does not hear from your insurance company within 30 days, we may request your help in contacting your insurance company to resolve the payment delay. Please supply your insurance card and a photo I.D. at each office visit.

Authorization for Release of Information: I authorize Falls Church Healthcare Center to disclose all or any parts of my medical record to my listed insurance company(s) and any review agency which conducts practice utilization review under a HIPPA agreement with patient's payment source. I also understand that I may revoke this authorization by providing written notice to Falls Church Healthcare Center.

Laboratory Billings: Your services may include laboratory studies required by your insurance company and or requested as a standard of care by your clinician. Your clinician will discuss the recommended additional tests as part of your care. Though the specimens may be collected at FCHC, these studies are NOT conducted at FCHC but sent to and conducted by an independent laboratory. That independent laboratory will file a claim to your insurance company separately. Any unpaid deductibles, co-insurance and copay as well as denials by your insurance company for those laboratory studies will be billed to you separately by the independent laboratory and will be your financial responsibility.

Payment of Services: I understand I am financially responsible for all charges and fees related to the services provided to me by FCHC. I understand that laboratory services if any that are provided by other than FCHC may incur charges separately billed by the laboratory. I further understand that payment in full for any unpaid amount is expected upon receipt of Falls Church Healthcare Center's first invoice. The invoiced charges may include unpaid co-payments, to be billed co-insurance amounts, unpaid deductibles and any fees for services not covered or denied by your insurance company such as medications and anesthesia. I understand I can request a payment plan to be arranged. I understand that 10% late fees may be attached to unpaid balances. I understand I am financially responsible for any legal fees and collection service fees related to the collection of my overdue outstanding balances.

Assignment of Benefits: I hereby authorize and request that my insurance company(s) make payment for my medical care directly to the Falls Church Healthcare Center or its assigns. In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payor.

I have read, understand and agree to this Participation and Authorization Agreement:

Patient Name (please print): _____

Signature _____ Date _____

FOR OFFICE USE: *Reviewed and verified by*_____