RELEASE OF BILLING INFORMATION AND ASSIGNMENT OF BENEFITS

Self Pay Patients

I am a self pay patient and I understand that I it is my responsibility to pay Diabetes and Endocrine Care of Virginia, LLC for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges that maybe incurred during this visit.

I understand that Diabetes and Endocrine Care of Virginia, LLC will report to commercial credit bureaus and may turn over my account to a collection agency when it becomes delinquent. Accounts having no payment within 60 to 90 days of the initial debt maybe consider delinquent for payment purposes.

I release Diabetes and Endocrine Care of Virginia, LLC its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information need to collect delinquent payment(s). I understand that I have the right to revoke this authorization at any time as long as I do It in writing.

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Signed (Patient or other Person Authorize to Act for patient)

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Print Name:

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Date & Time