Chesterfield Family Practice Center, P. C.
2500 Pocoshock Place, Suite 104
Richmond, Virginia 23235
804-276-9305
804-674-4145 (fax)

Release of Information and Collections Procedure Form

I authorize release of information necessary to file a claim with my insurance company. However, I understand that my insurance is a contract with my insurance carrier and not Chesterfield Family Practice and that I am responsible for all bills incurred.

I understand that payment is expected at the time of visit, unless previous arrangements have been made. In the event that this account is in default for non-payment and this contract is referred to an attorney, I agree to pay all costs incurred in the collection of my account, including a fee of one-third of the unpaid balance.

I further understand and agree that if suit is filed to collect this account, Chesterfield County, Virginia shall be an appropriate district for the filing and prosecution of any such suit.

_____	_____
Patient Name	Date
_____	_____
Patient Signature	Date of Birth
_____	_____
Responsible Party Signature	Relationship to Patient