Springfield MEDICAL CENTER, P.C.
Back & Neck Pain . Primary Care . Physical Medicine

Dr. Albert L. Valente
Board Certified Internal Medicine

Dr. Suzanne Lagosky
Board Certified Physical Medicine & Rehabilitation

CONSENT FOR TREATMENT, PAYMENT & ASSIGNMENT OF BENEFITS

I authorize the release of my medical information to my insurance company. I also acknowledge that I, the patient and/or legal guardian, am responsible for payment of services at the time services are rendered; and/or for any portion of the office visit that is not covered by my insurance. Insurance Assignment of Benefits is to be made to the physician.

If I have no insurance, or if this office does not accept my insurance, I agree to pay in full at the time services are rendered. I agree to pay 9% interest and any legal costs in association with collection of fees if I allow my account to become delinquent.

I also give consent to treatment and services that are considered medically necessary to my care. If at any time this office feels in good faith that it can no longer provide your medical care, or this is not longer a working doctor-patient relationship, you will be informed. Under Virginia statue you have 30 days to find another physician, upon written request we shall then forward your medical records to you new provider.

By signing below you are acknowledging that you have read, understood and accepted our office policy. Thank you.

Signature: _____ Date:_____

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