RADIATION ONCOLOGY SPECIALISTS OF CENTRAL VA

INSURANCE RELEASE

I hereby authorize my insurance company to pay benefits due directly to *Radiation Oncology Specialists of Central VA*.

I also understand and agree that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate my account, I shall be personally liable for the unpaid balance of the account.

Additionally, in the event that my account becomes past due, I agree to pay all fees and expenses (including reasonable legal fees and expenses) incurred to collect the account due. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE: _____