APT VIRGINIA

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORIZATION AND LIEN

To whom it may concern:

I _____ ("Patient") hereby authorize and assign APT Virginia ("Provider") such sums that may be due or become due for services rendered to me, both by reason of accident or illness. I further hereby irrevocably authorize and direct any insurance company and/or attorney to whom an original or copy of this assignment is provided to withhold from the patient and pay directly to the Provider such amount(s) from (1) any insurance benefit payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or any other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the Provider by the Patient. This assignment is to be complete and current transfer of Patient's right, title, and interest, separate from any statutory or contractual lien or claim to which the Provider may also be entitled. Patient Acknowledges that Provider has a substantial financial interest in the enforcement of this Assignment. I authorize the Provider to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above-mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I agree that in the event the insurance company and/or attorney obligated hereunder to make payments to the Provider fails or refuses to make payment for the full amount due as set forth above, I hereby assign and transfer to the Provider any and all cause of action that I might have or that might exist in my favor against such company and authorize the Provider to prosecute said cause of action either in my name or in the Providers name and I further authorize this office to compromise, settle or otherwise receive such claim or cause of action as they see fit. The Patient further agrees that the statute of limitations applicable to Provider's right to demand payment from the patient are ongoing.

I understand that I remain personally responsible for the total amount due to the Provider for these services.

I further understand and agree that if this Office must take and action to collect an outstanding balance on my account, I will be responsible for payment of, and will reimburse this Office, for all costs of such collection efforts, including but not limited to all court costs and all attorney fees, unless ordered by a court of law.

Notice: Automobile Accident Patients. If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense benefits coverage. By signing this assignment of benefits form you are giving to your health care Provider the right to receive some or all of that payment directly from your automobile insurance company. If you have health insurance and your healthcare Provider is in-network: as long as you provide information necessary to verify your health insurance coverage the healthcare provider may only bill the amount you owe for any co-payment, coinsurance, or deductible to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your healthcare Provider is not in your health insurer's provider network: your healthcare Provider may bill their full charges to your automobile insurance. You may want to consult your insurance agent or attorney before signing or initialing this form. You are not required to sign/initial this form to receive care. By initialing here, I acknowledge that I have read or had the opportunity to read this notice. _____ (Patient's Initials)

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE AND UNDER STATE LAW TO APT VIRGINIA. A photocopy of this assignment shall be considered as effective and valid as the original.

However, if you do not sign this form, you will be required to (1) pay any applicable co-payments, coinsurance and deductibles at the time the services are provided and allow us to bill your health insurance company or (2) pay for all care at the time of service.

Patient/ Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

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