UNIVERSITY of VIRGINIA
SCHOOL of EDUCATION and HUMAN DEVELOPMENT
Sheila C. Johnson Center

Sheila C. Johnson Center
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education.virginia.edu/research-initiatives/sheila-c-johnson-center

1. Download form to your computer desktop.
2. Open form with Adobe Reader, available at https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html
3. Save form after filling in the fields.
4. Return form via OnPatient

AGREEMENT TO PAY FOR SERVICES

Assignment of Benefits/Release of Information: In the event I am entitled to insurance benefits, Medicare or any recovery, I hereby assign the benefits of my insurance policy, Medicare or other recovery to the University of Virginia, to pay for the care provided at the Sheila C. Johnson Center. If applicable, I certify that the information given by me in applying the payment under Title XVIII of the Social Security Act is correct.

I authorize the Sheila C. Johnson Center for Clinical Services to release to the Centers of Medicare and Medicaid Services and/or to my health insurance company all information needed in order to consider payment of my claim for services rendered or as otherwise requested by them.

Note: Insurance Companies do NOT provide coverage or payment for the following services: Educational Testing, Diagnostic Educational Evaluation, Diagnostic Literacy Evaluation, Special Education Observation/Assessments, Reading Services and Tutoring, and Career Counseling or Consultation. These services are the financial responsibility of the client.

Financial Statement: In consideration of services furnished or to be furnished, I guarantee payment to The University of Virginia Sheila C. Johnson Center of all outstanding balance incurred or to be incurred including those paid by any third party source. I understand that I am responsible for all charges not covered by my insurance company. If payment is not made when due, I agree to pay all reasonable costs and expenses related to collection of any outstanding balances, including but not limited to reasonable attorney's fees.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Name of Client (please print): _____

Name of Person Agreeing to Pay (please print): _____

SSN of Person Agreeing to Pay: _____ Relationship to Client: _____

Signature of Person Agreeing to Pay: _____ ☐ Date: _____

Check Box to Sign

If you do not have access to a digital signature, please check the box as an indication that you have read and understand this document.

Mailing Information

My monthly billing statements are to be mailed to the following address:

_____

_____

To protect your privacy, the Center will only address and send invoices to the person/s listed above. However, for your convenience, payment will be accepted from other family members or persons presenting payment on your behalf.

(OPTIONAL): Please list persons, if any, who you **do not** authorize to make payments.

_____

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