FINANCIAL POLICY & PATIENT RESPONSIBILITY ***Laura Wagner, Inc.***

It is the responsibility of the patient or their legal representative to understand their insurance. The contract is between the patient and their insurance company. We will file your claim to your insurance if we participate with your plan. You should contact our office immediately if you have questions about your bill. You should respond to all requests for information upon receipt.

Referrals: You are responsible for knowing if referrals are required by your plan. If a referral is required, you are responsible for obtaining a referral **before** receiving services.

Multiple insurances: You are responsible for knowing and informing us which insurance is primary, secondary or tertiary.

Updated Information: You should present all insurance cards at **each** visit. It is your responsibility to make sure we have the patient's current contact information, billing address, phone numbers, and all insurance information **before** each visit. You will be responsible for payment of unpaid claims resulting from providing incorrect or incomplete information **before** services are rendered.

Patient Billing/Payment Plans: We will balance bill the responsible party after the insurances have processed. You will be billed for deductibles, copays, co-insurance and non-covered services. Bills are due upon receipt of the first notice. After that, they are considered past due. If you are not able to pay in full upon receipt of the first bill, it is your responsibility to contact our office to discuss payment arrangements as soon as possible. Unapproved partial payments are not tracked as payment plans in our system and your account could be placed into collections if the balance is not paid in full before the billing cycle runs its' course.

Bad Debt & Collection Action/Non-sufficient Funds: If your account is placed in collections, you will be responsible for reasonable collection and/or attorney fees incurred. If your account has a past due balance, or is in collections, Laura Wagner, Inc. may suspend services until payment has been received in full, or she may dismiss you as a patient. If your check or credit card payment is returned for non-sufficient funds or any other reason, you will be charged a reasonable fee associated with the returned payment.

Outside services: We may order services for you, including but not limited to pathology, radiology, emergency services, prescriptions, and other special services and tests. Those services are billed separately from Laura Wagner, Inc. services. You are responsible for payment of those services directly to those providers.

ASSIGNMENT OF BENEFITS and AUTHORIZATION TO RELEASE INFORMATION

◊ **Patients with *MEDICARE PLANS:*** I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents, any information needed to determine these benefits payable for related services. I request payment of authorized Medicare benefits be made on my behalf to Laura Wagner, Inc. for any services furnished me by her. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for applicable Medicare Part B deductible, copays, coinsurance amounts & any non-covered services.

◊ **Patients with *MEDIGAP* coverage:** I request that payment of authorized Medigap benefits be made on my behalf to Laura Wagner, Inc. for any services furnished me by her. I authorize any holder of medical information about me to release to my Medigap insurer, any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for applicable deductible, copays, coinsurance amounts & any non-covered services.

◊ **Patients with *OTHER INSURANCE*:** I request that payment of any authorized insurance benefits to be made on my behalf to Laura Wagner, Inc. for any services furnished me by her. I authorize any holder of medical information about me to release to my insurer, any information needed to determine benefits payable for services from this provider. I understand that I am responsible for any co-pay, co-insurance, deductible and non-covered services.

◊ **Patients who are *Self-Pay:*** Payment is due for all services at the time of service unless other arrangements are made in advance.

CONSENT TO TREAT: By signing this form, I authorize my physician and her associates and staff to provide and perform such medical care, tests, procedures, drugs and other services and supplies, as considered advisable by my physician, all for my health and well-being. This may include pathology, radiology, emergency services, prescriptions, and other special services and tests ordered by LWI. I acknowledge that no representations, warranties, or guarantees as to result or cures have been made to or relied upon by me.

ASSIGNMENT OF BENEFITS: By signing this form, I acknowledge that I have read and agree to the terms of the Financial Policies and the Assignment of Benefits explained in this notice.

(This authorization will remain in effect until revoked in writing or replace by a new authorization.)

_____	_____
Patient Name (PRINT)	Patient Date of Birth
_____	_____
Signature of Patient or Legal Representative	Date Signed
_____	_____
Name if not Patient (PRINT)	Relationship to Patient