LAURA WAGNER, INC. (LWI)
FINANCIAL & BILLING POLICY/CONSENT FORM

FINANCIAL AND BILLING POLICY

The practice will file your claim to insurance if we participate with your plan.

Patient Responsibility

- Provide complete, current and updated insurance information.
- Pay copays and non-covered services at the time of service.
- Pay patient balances upon receipt of bills unless otherwise arranged.
- Provide referrals before services are provided, if a referral is required.
- Provide your current and updated billing address, phone and contact information required for billing.
- Provide upon request, any information requested from the insurance payor, or from LWI, that is needed to process claims.

Payment Plans

You will be balance billed after insurance has processed your claims. Payment is due in full by the due date on your bill. If you cannot pay your balance in full, contact our office to discuss payment arrangements to avoid collection activity. Payment plans must be approved by our office.

Delinquent Accounts

If an over-due patient balance is sent to collections, you are responsible for reasonable collection and/or attorney fees. Dr. Wagner may refuse further care if your account is sent to collections. You should contact our office immediately if you have questions about your bill.

Non-sufficient Funds

You will be charged a reasonable fee for any non-sufficient funds notice from the bank.

ASSIGNMENT OF BENEFITS

◊ Patients with *MEDICARE:*

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, coinsurance amounts & any non-covered services.

◊ Patients with *MEDIGAP* coverage*:*

I request that payment of authorized Medigap benefits be made on my behalf to LWI 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 non-covered services.

◊ Patients with *OTHER INSURANCE*:

I request that payment of any authorized insurance benefits to be made on my behalf to LWI 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.

MEDICAL CONSENT: 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.

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

Patient Name [please print]: _____

Signature: X_____ **Date:** _____

If signed by someone other than the patient, what is the relationship to the patient?

□ Parent □ Legal Guardian □ Other _____