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

Please sign and date.

FINANCIAL AND BILLING POLICY

Patient Responsibility If you want us to file your claim, you must:

- Provide complete, current and updated insurance information.
- Provide your current and updated billing address, phone and contact information required for billing.
- 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 upon request, any information requested from the insurance payor, or from LWI, that is needed to process claims.

Payment Plans and Delinquent Accounts

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. 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. You should contact our office immediately if you have questions about your bill.

DISCLOSURE

Authorized Contacts provided are people with whom LWI & representatives may discuss appointments, medical care, account info, etc. The patient, guardian, emergency contacts, next of kin, guarantor and the insured members are considered as authorized contacts.
Automated Text Alerts: LWI may leave automated text alerts on your mobile phone about appointments, results, and more.
Automated Phone Calls: LWI may leave automated phone calls on your mobile phone about appointments, results, and more.
Medication History Downloads: It is the practice of LWI to download the patient medication history into the patient chart form the pharmacy benefit managers, via Surescripts. This may include information related to alcohol & drug abuse, mental health treatment & HIV related information, with details of prescriptions you currently take or have taken in the past.

Notice of Privacy Practices

You will be provided a copy of our NPP at check-in. It is also available at wagnerderm.com This explains how your protected health information may be used or disclosed, and how to get access to this information. Review it and notify LWI of any questions or concerns.

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.

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CONSENT Please sign and date below to give consent. You may cross through & initial lines if you do not give consent to that line.

FINANCIAL: I have read and understand the financial policy described in this document, and agree to the terms.
DISCLOSURE/Authorized Contacts: I acknowledge that I have read and understand how LWI may use authorized contacts.
DISCLOSURE/ Consent to Text: I authorize LWI to send automated text alerts to my mobile phone as described above.
DISCLOSURE/ Consent to Call: I authorize LWI to send automated phone calls to my mobile phone as described above.
DISCLOSURE/Medication History Download: I give consent to LWI to download my medication history as described above.
DISCLOSURE/NPP: I acknowledge that a copy of the LWI Notice of Privacy Practices has been made available to me.
ASSIGNMENT OF BENEFITS: I authorize the Assignment of Benefits to LWI or their designee for services rendered.
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.

Patient Name: _____ Date: _____

_____ X_____ _____

Print Responsible Person Name if other than Patient | Signature of Patient or Responsible Person | Relationship