WAGNER INTEGRATIVE THERAPIES *SM*

875 N. Easton Rd Ste 5B * Doylestown, PA 18902
215-230-8100 ph * 215-230-8892 fax
WagnerITinfo@gmail.com

BENEFIT ASSIGNMENT
&
FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You may be responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, we may request that the balance be paid in full by you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal (usual and customary fee schedule), you may be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Taormina Management, LLC/ Wagner Integrative Therapies *SM***.

* **Worker's Compensation:** The above may not apply for those patients that have an active WC claim. Be advised that if you claim Worker's Compensation benefits and are subsequently denied, WIT reserves the right to submit outstanding bills to your primary health insurance carrier. You may be held responsible for all or some of the charges for services rendered to you, in the event that your benefits are terminated, and you require continued treatment.
* **Auto Accidents:** We require that you present secondary health insurance at the time of your evaluation. In the event that your auto benefits exhaust prior to completion of treatment, we reserve the right to submit your unpaid bills to your health insurance carrier, unless you agree to pay for care out of pocket.
***Personal Injuries:** The above private health insurance and/or private pay policies apply if you have a **Personal Injury** claim. We will happily provide your attorney with treatment notes and bills but cannot defer your bills while you are engaged in a lawsuit for an injury, under any circumstance.

When you pay by check: you expressly authorize **Taormina Management, LLC/ Wagner Integrative Therapies *SM* (if your check is dishonored for any reason)** the right to charge you a returned check fee of $35.00 plus the amount of the check. The above language authorizes an electronic debit to your account for the recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not; however, mean that **Taormina Management, LLC/ Wagner Integrative Therapies *SM*** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I understand and agree that **Wagner Integrative Therapies *SM*,** requires a minimum of 24 hours notice for cancellations and/or appointment changes**.**

Information Privacy: **Taormina Management, LLC/Wagner Integrative Therapies *SM*** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and will make copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to Taormina Management, LLC/ Wagner Integrative Therapies SM . A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

Patient Name(Print)_____Date:_____

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Signature: Patient/Guardian/Responsible Party