Reset

ASSIGNMENT OF BENEFITS

DATE: _____

BENEFITS ASSIGNED TO: **Walking and Wheeling, LLC**

MAKE ALL CHECKS PAYABLE FOR THIS CLAIM TO: **Walking And Wheeling, LLC**

BENEFITS ASSIGNED

PATIENT INFORMATION

PATIENT NAME:_____
DATE OF BIRTH: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
COMPANY NAME_Make Selection
ADDRESS_____
CITY/STATE_____ZIP_____
TELEPHONE_____
POLICY #_____GROUP#_____
POLICY HOLDER NAME:_____DATE OF BIRTH_____

SECONDARY INSURANCE
COMPANY NAME_NONE
ADDRESS_____
CITY/STATE_____ZIP_____
TELEPHONE_____
POLICY #_____GROUP#_____
POLICY HOLDER NAME:_____DATE OF BIRTH_____

TERTIARY INSURANCE
COMPANY NAME_NONE
ADDRESS_____
CITY/STATE_____ZIP_____
TELEPHONE_____
POLICY #_____GROUP#_____
POLICY HOLDER NAME:_____DATE OF BIRTH_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of medical benefits directly to Walking and Wheeling, LLC. I further authorize the release of any medical information necessary to only to process the insurance claim on my behalf. I permit copy of this document to be valid as the original.

Signature/Date_____

Walking and Wheeling, LLC
W4652 Glenn Street
Appleton, WI 54913

Patient Name:
Date of Birth:

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature of Patient or Legal Representative Witness

Date Notice Effective Date or Version

_X_ Accepted _____ Denied

Signature/Date_____

*For any concerns or complaints regarding your visit, please contact Bryan at 920-968-7528
*ATENCIÓN: si habla español, dispone de servicios gratuitos de asistencia lingüística.Correo electrónico: info@walkingandwheeling.com
*NCO TSEG: Yog koj hais lus Hmoob, kev pab txhais lus yog tsis tau them nqi. Email:info@walkingandwheeling.com

Walking and Wheeling, LLC
W4652 Glenn Street
Appleton, WI 54913

W4652 Glenn Street
Appleton, WI 54913
Tel 920.968.7528 Fax 866.878.1996
Bryan@walkingandwheeling.com
WalkingandWheeling.com

WALKING AND WHEELING
'we get kids moving!'

Patient Name:
Date of Birth:

Patient Financial Policy

Thank you for choosing Walking and Wheeling as your healthcare provider. We value the relationships we have built with our patients and are committed to maintaining a successful provider-patient relationship with you and your family. Thank you for understanding that payment for services is part of that relationship. Our financial policy assures that we can continue to provide quality care to all our patients, while being sensitive to economic challenges many of us face.

Payments

Payment in full is expected on receipt of your billing statement. If a balance is due, your billing statement will reflect the amount you owe. If no resolution can be made within thirty (30) calendar days, the account will be sent to the collection agency and discharge from the practice may be initiated. Patients are entitled and encouraged to seek financial solutions by Walking and Wheeling's Patient Financial Specialists who can offer possible solutions for those who cannot pay in full at time of service. Walking and Wheeling Patient Financial Specialists work with the patient and /or guarantor to find reasonable payment alternatives. We trust you will understand the need to establish these payment standards for all our patients. If you need further information, please don't hesitate to ask.

Co-Payments

All co-payments are expected at the time of check-in. Failure to pay co-payment at the time of service may result in a delay in scheduling future appointments.

Missed Appointments

If you need to cancel an appointment, we require at least a 24-hour notice. This allows us to offer the appointment to another patient. If a same day cancellation is necessary due to an emergency or illness please still let us know prior to the scheduled appointment time. If you fail to keep your appointments without letting us know in advance, after two missed/canceled appointments there will be a $50.00 charge and you may be discharged from the practice so that we can provide care to other patients.

Returned Checks

The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) are responsible for full payment.

*Signature/Date*_____

This financial policy helps the office provide quality care to our patients. If you have any questions or need clarification of any of the above policies, please ask a staff member.