Live Smarter Nutrition & Wellness
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# Signature on File, Assignments of Benefits and Financial Agreement

Provider: Lindsay R Schmitz, MS, RD, LDN
Live Smarter Nutrition & Wellness

Patient Name _____ Insurance ID Number _____

1. **Medicare**:

I request that payment of authorized Medicare benefits be made on my behalf for services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The provider accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **Other Insurance**:

I understand that the provider is contracted for numerous health insurance plans. The provider will to the best of their ability make available the names of healthcare services plans with which they contract. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me if I (the undersigned) belong to a plan with which the provider has no contractual relationship to provide health care.

3. **Non-Covered Services**:

I understand that the provider contracts with health care service plans (i.e. HMOs, PPOs,) relate only to items and services which are "covered" by that plan. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by his health care service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with their insurance plan or not in the benefit summary the health care service plan furnishes to the patient; and treatment not authorized by their plan. The undersigned agrees to cooperate to obtain all necessary health care service plan and insurance authorizations.

4. **Financial Agreement**:

I agree that in return for the services provided to the patient by the provider, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the provider for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not necessarily by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any health care benefits insuring the patient, or any other party liable to the patient, for medical services provided by the provider is hereby assigned to the provider. If co-payment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the provider.

However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Beneficiary or Authorized Party Signature Date

Updated 03/2022