ADVANCED
WOUND CARE

PATIENT CONSENT TO BILL INSURANCE POLICY

Effective Date: January 1, 2026

Practice Name: Advanced Wound Care Services LLC
Contact: billing@awc-services.com

Purpose: This policy authorizes Advanced Wound Care Services LLC to bill the patient's health insurance for services provided, obtain payment directly from the insurance company, and release any necessary medical or billing information required to process claims. This ensures accurate and timely insurance reimbursement while informing the patient of their financial responsibilities.

Authorization to Bill Insurance

- I authorize Advanced Wound Care Services LLC to submit insurance claims for services rendered on my behalf.

Assignment of Benefits

- I assign and authorize direct payment of medical benefits to Advanced Wound Care Services LLC for services provided.

Release of Information

- I authorize the release of any medical information necessary to process my insurance claims.

Financial Responsibility

- I understand that I am financially responsible for any portion of charges not covered by my insurance plan, including co-payments, deductibles, and non-covered services.

Electronic Submission Consent

- I consent to the electronic submission of claims and related documentation as needed for billing and reimbursement.

ACKNOWLEDGMENT

I acknowledge that I have read, understand, and agree to Advanced Wound Care Services LLC's Consent to Bill Insurance Policy.

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Patient Name (Printed):

Signature: _____ Date: _____