



**STATERA**

Integrated Health & Wellness Solutions

3375 Lake Ridge Dr. Dubuque, IA 52003  
Phone: (563)-207-8932 Fax: (563) 207-8935

## ASSIGNMENT OF BENEFITS

I hereby authorize and request that payment of benefits by my Health Insurance Provider at the time that services are rendered to me by Providers contracted with Statera Health and Wellness Solutions, LLC be made directly to Statera Health and Wellness Solutions, LLC for such services furnished to me or my dependent.

I understand that my insurance company may only cover a portion of the total bill.

I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Statera Health and Wellness Solutions, LLC to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of Statera Health and Wellness Solutions, LLC. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Statera Health and Wellness Solutions, LLC, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist Statera Health and Wellness Solutions, LLC or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Statera Health and Wellness Solutions, LLC is acting on my behalf in filing for insurance benefits assigned to it and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Statera Health and Wellness Solutions, LLC for billing and collection purposes may do billing.
7. Statera Health and Wellness Solutions, LLC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be authorized.
9. Statera Health and Wellness Solutions, LLC shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date