Financial Policy

AUTHORIZATION TO RELEASE INFORMATION

You agree that all records concerning your care with Comprehensive Sleep Center, PC shall remain the property of Comprehensive Sleep Center, PC. You understand and agree that such information is used AND authorize release of medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to **Comprehensive Sleep and Breathing Disorders Center** any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. Release of records may be needed for Accreditation, certification, licensing or credentialing activities of Comprehensive Sleep Center, PC. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to **Comprehensive Sleep and Breathing Disorders Center** for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with **Comprehensive Sleep and Breathing Disorders Center**, I am not responsible for amounts that are agreed to be written off. If my insurance does not have a contract with **Comprehensive Sleep and Breathing Disorders Center**, I agree to be responsible for any amounts not paid by my insurance plan. Your credit card on file will be used for these types of payments. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fee. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

ADDITIONAL CHARGES

- No Show Charge **$30, for follow up** if not notified within 24 hours prior to your appointment.
- No Show Charge **$50**, for PFT or New patient if not notified within 24 hours prior to your appointment

WRITTEN ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I (we), the undersigned patient and/or responsible party hereby authorize Comprehensive Sleep & Breathing Disorder Center, PC, its physicians, agents, employees or representatives to discuss or release any and all patient information about me, including, but not limited to, past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person or persons indicated below:

THIS AUTHORIZATION WILL EXPIRE AFTER ONE (1) YEAR.

___Spouse Name:_____Tele:_____

___Children/Parent(s) Name:_____Tele:_____

I hereby acknowledge that I have had an opportunity to ask questions concerning the Notice of Financial and Privacy Practice of **Comprehensive Sleep and Breathing Disorders Center.**

_____ _____

Patient's Name Printed Patient's Date of Birth

_____ _____

Patient's Signature Date