Statement of Patient Financial Responsibility

Patient Name: ____ DOB: ________________________

The office of Sleep-Wake disorders Center of Havasu appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are also responsible for payment of any deductible (see high deductible below) and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer and if your insurance carrier denies any part of your claim, you will be responsible for your balance in full. You will be sent a bill for the amount due for services not covered or that were denied and you agree to pay the bill within 15 days of receipt and/or call our billing office to discuss your bill. You also agree that if you do not contact our billing office regarding any billing correspondence or send payment within the 15 days time frame that we may charge your credit card (if) on file for the amount of the bill. You also agree that our office may charge reasonable interest to the unpaid bills balance.

I have read the above policy regarding my financial responsibility for services rendered by Sleep-Wake disorders Center of Havasu to the above named patient or me. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Sleep-Wake Disorders Center of Havasu, the full and entire amount of bill incurred by the above named patient; or me or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature ____ Date ____________________________

Guarantor Signature ____ Date ____________________________
(If guarantor is not the patient)

Co-Pay and Co-Insurance Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated that this payment be made at the time the service is rendered. If the exact amount of your co-pay/co-insurance can't be verified then it is the office policy to collect $35.00 up front to cover any Co-pay or Co-insurance charge that may be required by your insurance carrier. If after we process your payment from the insurance company and the co-pay or co-insurance was less than the $35.00 charged, our office will promptly send you a check for the difference. Thank you for your cooperation in this matter.

High Deductible Insurance Policies

At the time of service, it is our policy to attempt to determine the balance of your deductible. If your deductible balance is higher than that of the amount of the service being rendered, it is expected and appreciated that payment be made at the time the service.

I acknowledge and accept Co-Pay and Co-Insurance Policy and High Deductible Insurance Policies

Patient/Guarantor Signature ____ Date ______________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize the Sleep-Wake Disorders Center of Havasu, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize the office of Sleep-Wake disorders center of Havasu, to release to appropriate insurance or medical providers, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature ____ Date ______________________________

Patient Name: ____ DOB: ____________________

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment to avoid being charged a No Show fee.
I understand if I do not give a 24 hour notice of cancelation and miss my appointment I will be charged a $50.00 fee.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____________________________________ Date _________________________

Self-Pay

I do not have health insurance and will be responsible for services rendered by Sleep-Wake Disorders Center of Havasu I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____________________________________ Date _________________________

Payment method:

Credit Card:
Circle one: Visa MasterCard American Express Discover

Name on card:________________________________ Expiration date:_________

Card number:_________________________________ Security Code: ___ ___ ___

Billing Zip Code: ____________ Amount:_________

Check:
Check number: _________ Amount: ________

Cash:
Amount: __________

Note: If you would like a copy of this Policy, please inform the receptionist.