Georgetown Sleep Center, PA Patient Consent - Notice of Privacy Practices/ Assignment of Benefits/Financial Policy/Release of Information:

I authorize all staff at Georgetown Sleep Center, PA to provide treatment as necessary. I acknowledge that no guarantees can be made to me as to the outcome of treatment. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I authorize my insurance benefits to be paid directly to my physician realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

Financial Policy-Georgetown Sleep Center, PA

We require payment at time of service and will accept personal checks, cash, VISA, MasterCard, American Express, and Discover. Our practice accepts most major insurance carriers and we will file your claim with your insurance company. We strongly believe that the best medical service is based on a mutual relationship of trust, confidence and respect. We therefore invite you to discuss with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our Business/Billing Office at (512) 212-3202.

Payment Options:
Private Pay/ Uninsured Patients: We strive to provide quality care for those in our community that do not have access to affordable health care coverage. Payment is expected at the time services are rendered. Therefore, our Self Pay Patients may receive a special discounted fee at the time of check out. For extensive services you may secure a loan with your financial institution or Credit Card Company.

Insured Patients: You must provide a current copy of your insurance card to the receptionist at the time of service. You must pay all deductibles, copayments, and co-insurances in full at the time of service or promptly when you receive a statement. You may choose to pay with cash, check, or credit card. Georgetown Sleep Center will file your insurance claim with your carrier. Although we may estimate the portion your insurance may pay, it is the insurance company that makes the final determination of eligibility and payment. Insurance is a contract between you and your insurance company. Per your insurance contract, it is your obligation to pay those charges not covered by your insurance company.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. Payments not received within 25 business days of receipt of this statement are considered past due. If you have a credit on your account, it is the patient's responsibility to request the refund on their account. Any refund balance left in the account after six months could forfeit a $30 administrative fee for processing. Please request refunds after receiving a final statement from your insurance Plan.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. These accounts will receive a past due letter and are subject to collection activity. This includes account review for collection agency follow-up and reporting. If your account is sent to an outside collection agency, you may be subject to agency fees, penalties and credit bureau reporting.

Missed Appointments: We understand that our patients' time is valuable and we know that our patients understand that the physician's time is valuable as well. Therefore, a missed appointment fee will be assessed to any appointment not cancelled without prior notice. For office visits, a 24 hour cancellation is required to avoid the $35.00 missed appointment fee. For sleep studies, we require a 72 hour cancellation notice or $250.00 will be charged to your account. Full payment of these fees will be required before rescheduling your appointment. ***Please remember that appointment confirmation is provided as a courtesy only and it is the patient's responsibility to remember their appointment time.**

Good medical care requires a mutual relationship of trust, confidence and respect. Persistent failure to keep scheduled appointments may result in dismissal from the practice.

Returned Checks: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to making a new appointment. Future visits will need to be paid in cash. All returned checks left unpaid after 25 days will be considered past due.

Workers Compensation/Personal Injury:
We do not accept Worker's Compensation or Personal Injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time services are rendered.

____ **Medicaid**
We do not accept or file Medicaid claims primary or secondary.

Additional Services: Please be aware that there may be fees for additional services such as medical records, depositions, or special forms. Please check with the Office Manager for specific fees for additional services.

Any disputes of your account should be done in writing within 25 days of the receipt of your statement. Your dispute will be addressed immediately and you will be notified of the outcome within 30 days of the receipt of your dispute.

RELEASE OF INFORMATION

I hereby authorize Georgetown Sleep Center to release my information to my medical provider such as physician, medical equipment company, emergency medical services (transport), or hospital as well as any insurance company and/or responsible billing party in order to carry out medical treatment, payment and healthcare operations. This information may include diagnosis, records of any treatment, or any examinations rendered.

I authorize the release of information to my insurance carrier concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. Any release of information to individuals of my choosing will be authorized in the office. I understand that the release of information will only consist of medical records belonging to Georgetown Sleep Center, PA.

I understand all online communications will be used only for limited purposes. If there is any information that I do not want transmitted via online communication, I must inform this practice in writing. I understand this office cannot be held responsible.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician staff and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

Print Patient Name_____ Patient Date of Birth_____

_____ _____
Patient's Signature Date

This is an agreement between Georgetown Sleep Center, PA and the Patient named on this form. By executing this agreement, you (the Patient/Guarantor) are agreeing to pay for all services rendered. Please understand that insurance coverage is not a guarantee of benefits and does not release you from any financial obligation to pay for services rendered by Georgetown Sleep Center, P.A.