

Sleep Clinic of America

FINANCIAL POLICY AGREEMENT

Sleep Clinic of America utilizes Pay Span, Patient Payment Assurance to securely maintain your payment information in compliance with federal and state laws. Your payment information filed with Pay Span will be saved for future processing of patient responsible portions not paid by insurance: miscellaneous healthcare fees, such as but not limited to: late, cancelled, or missed appointments. Your payment information will not be processed for services covered under your active medical insurance policy with the exception of copays, deductibles, and non-covered services. If your insurance carriers, after processing your claim, determines that you are responsible for any portion of the services rendered, your form of payment will be charged after we contact you. If you have a copay or deductible as a part of your insurance policy, that amount will still need to be paid at the time of your visit, in which this information is available to our staff. The financial transactions will in no way compromise your ability to dispute charges incurred or question insurance determination of coverage. If for any reason we are unable to reach you to retrieve funds, we will run a report to locate your new address in the event you have moved away prior to paying any balance owed on your account. We want to avoid having your account sent to collections. If you are not a local resident, or have a secondary address, please provide us with both addresses. I authorize Sleep Clinic of America to process financial transactions to pay my account balance. I agree to be financially responsible for any and all related charges if they are not covered by my insurance.

Sign: _____ Date: _____

Sleep Clinic of America

Financial Responsibility

PATIENT NAME: _____ DATE: _____

- I hereby assign all medical benefits to include major medical benefits to which I am entitled, including but not limited to, Medicare, Medicaid, Private Insurance, and any other health plan to Dr. Dacelin St. Martin and Sleep Clinic of America.
- This order will remain in effect until revoked by me in writing.
- A photocopy of the assignment is to be considered as valid as the original.
- I understand that I am financially responsible for all charges whether or not paid by said insurance.
- I hereby authorize said assignments to release all information necessary to secure payment.
- The guarantor named above agrees to be personally and fully responsible for the payment of any and all medical services, not covered by a Federal, State, or commercial insurance or benefit program, that are provided by Sleep Clinic of America to the above named individuals.
- I understand that I am personally and fully responsible for the payment of all applicable copayments and deductibles. I understand that all applicable payments are due at the time of service and that it is only an explanation of benefits, not a guarantee of payment by my insurance.
- By signing below I acknowledge that I have read the financial policies above, and on the previous page, and understand and agree to accept and abide by them.

Sign: _____ Date: _____