WE APPRECIATE THE OPPORTUNITY OF SERVING YOU

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1 ½ percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company which costs will not exceed 20% of said unpaid balance, including a reasonable attorney fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. You are also responsible to check if Sweet Dreams Sleep Clinic is network with insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either my insurance company or me at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the provider, **Sweet Dreams Sleep Services**, to release any medical information including diagnoses, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the provider deems it necessary to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

Signed: _____ Date: _____
Patient, Parent, or Guardian

IN CASE OF EMERGENCY CONTACT: (NAME) _____

PHONE NUMBER: _____ RELATIONSHIP: _____