Pacific Sleep Program

CONDITIONS OF REGISTRATION

Medical Consent

- I consent to the provision of health care services at Pacific Sleep Program and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, and medical treatment. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- I acknowledge that the health care provider(s) treating me may be independent contractors, not employed by Pacific Sleep Program.
- I understand if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required.
- I understand that some clinics are teaching institutions and I consent to residents and students being involved with my care. I understand these caregivers are under the supervision of qualified health care instructors at all times. I understand that I will be informed whenever possible of the resident or student status of specific caregivers.

Financial Agreement: As a courtesy to you, our office will bill your insurance company on your behalf for services rendered, provided complete and accurate information is provided at the time of each visit.

- I understand full payment is required at the time of service for all co-payments, deductibles, and services or products not covered by or not billable to my insurance company.
- I understand I am responsible for services not covered by my insurance or other agency, which may include deductible and coinsurance. If insurance payment is not received after 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing.
- I understand I will be charged a fee of **$75.00 for a missed provider appointment** or if I cancel my appointment in less than 24 hours.
- I understand if I cancel my appointment with the Sleep Lab in **less than 24 hours** of my scheduled appointment time, I will be charged a fee of **$150.00.**
- I understand there is a **$150.00 charge for a missed appointment with the Sleep Lab.** I understand if this account is turned over to a third party collection agency, all services after that are deemed **'Cash only'** and payable in full at the time of service.
- I understand all late cancellation fees and missed appointment fees are **NOT** payable by my insurance company and will be billed directly to me.
- I understand if I have two late cancellations, two no shows or one of each, I may be discharged from the practice.
- I understand I will be charged a **$35.00 service charge on all returned checks.**
- I understand if my insurance requires me to have a referral for services provided by Pacific Sleep Program, it is my responsibility to obtain the referral.

Financial Certification: I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

By signing below, I (Patient or Authorized Consenter) hereby acknowledge I have read and fully understand the above information. I have asked questions about anything not clear to me, and am satisfied with the answers I have received. I understand that I may revoke my consent or authorization at any time except to the extent that action has been taken in reliance on such consent or authorization.