

Sleep Innovations

SLEEP SPECIALTY CLINIC

Debit/Health Savings/Credit Card Payment Authorization Form

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. To accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you agree to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by the practice. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date and the last 4 digits of the card number.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. Please contact our office immediately after receiving your first statement to set up this payment plan as soon as possible. After 45 days of no payment or notification to set up a payment plan, your card will be charged the balance without notification.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a collection letter for any outstanding balance. I am responsible for paying this balance by its due date to avoid being turned over to an outside collection agency.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

Cardholders Name as it Appears on Card

Card Number (MasterCard, Visa, Discover, American Express)

Sleep Innovations

SLEEP SPECIALTY CLINIC

Expiration Date _____

Verification Code (3 or 4 Digits) _____

Patient Signature: _____ Date: _____