

Sleep Innovations

SLEEP SPECIALTY CLINIC

PATIENT NAME _____
FIRST M.I. LAST PREFERRED NAME

DATE OF BIRTH _____ MARITAL STATUS () Married () Single () Divorced () Widowed () Separated

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL # _____ WORK _____ HOME _____

SEX () MALE () FEMALE SOCIAL SECURITY # _____

EMAIL ADDRESS _____

REFERRING DR. _____ FAMILY DR. _____
(IF DIFFERENT FROM REFERRING)

OCCUPATION _____ PATIENT EMPLOYER _____

SPOUSE (IF PATIENT IS A MINOR, USE PARENT) _____

SPOUSE (IF PATIENT IS A MINOR, USE PARENT) WORK # _____ CELL # _____

EMERGENCY CONTACT (OTHER THAN SPOUSE/PARENT IF AVAILABLE): This form also gives us permission to contact this person in regard to your care.

NAME _____ RELATIONSHIP _____

CELL # _____ WORK _____ HOME _____

****PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST FOR COPYING****

PRIMARY INSURANCE _____ ID # _____ GROUP # _____

POLICY HOLDER NAME _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ ID # _____ GROUP # _____

POLICY HOLDER NAME _____ RELATIONSHIP TO PATIENT _____

IF POLICY HOLDER IS SOMEONE OTHER THAN THE PATIENT, PLEASE FILL OUT THE FOLLOWING:

POLICY HOLDER'S EMPLOYER _____ DATE OF BIRTH _____

POLICY HOLDER'S SOCIAL SECURITY # _____

FLIP OVER 

PATIENT RIGHTS and RESPONSIBILITIES

Consent for Release and Use of Confidential Information & Receipt of Notice of Privacy Practices

I hereby give my consent to Sleep Innovations to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I acknowledge that I am aware of Sleep Innovations Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed and stated my right with respect to my medical information, effective 4/14/03. I understand that in the event that the Notice is revised, the revised Notice will be available at Sleep Innovations and that I may obtain a current Notice of Privacy Practices at any time from the privacy officer at Sleep Innovations. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree with my requested restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Financial Responsibilities

I authorize direct payment of medical benefits and/or private insurance benefits on my behalf for any services furnished to me by Sleep Innovations to be submitted directly to their office. I authorize the release of any medical information necessary to coordinate care with other physicians and to process claims. I understand that I am financially responsible for all charges whether or not paid by my insurance company. Additionally, if the account is turned over to a collection agency, I am aware that a **\$40.00** service fee is added to the balance to cover the cost of the collections efforts made by the office. I understand that more and more insurance companies are requiring preauthorization for office visits, referrals and testing. Therefore, it is my responsibility to check with my insurance company for specific requirements of my plan.

Cancellation & No-Show Policy Responsibilities

At Sleep Innovations, our goal is to provide quality individualized medical care in a timely manner. No show and late cancellations inconvenience those individuals who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation Policy:

To be respectful of the medical needs of other patients, please be courteous and call Sleep Innovations if you are unable to show up for an appointment. This time will be reallocated to someone who needs treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Appointments which are cancelled with less than 24 hours notification may be subject to a **\$25.00** cancellation fee.

No Show Policy:

A No Show is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "No Show" and a fee will be charged as follows:

- First No-Show Appointment: A phone call will be made to the patient.
- Second No Show Appointment: **\$40.00** fee will be billed to your account.
- Third No Show Appointment: **\$40.00** fee will be billed to your account, and you will be **discharged from our practice.**

These fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived pending management approval. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about these fees should be directed to our billing department.

Please sign that you have read, understand and agree to these Patient Rights and Responsibilities.

Name of Patient/Guardian/Representative (PRINT NAME)

Date

Signature of Patient/Guardian/Representative (SIGN)

If Guardian/Representative - Relationship to Patient