Southeast Regional Sleep Disorders Center

Release of Information, Assignment of Insurance Benefits, and Financial Agreement

Patient: _____ Account #: _____

A. **Release of Information, Assignment, and Authorization to Pay Insurance Benefits:**
The sleep center, my physician or physicians, may disclose all or any part of the patient record to any person which is or may be liable for or responsible for payment of all or part of the sleep center and/or physician charges, including, but not limited to, insurance companies, medical or lab service companies, workmen's compensation carriers, employers, and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a Medicare or Medicaid claim. In consideration of Southeast Regional Sleep Disorders Center advancing or extending credit for sleep diagnostic procedures, the undersigned hereby assigns and transfers to Southeast Regional Sleep Disorders Center all benefits and payment now due and payable or to become due and payable to the patient under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, worker compensation policy or program, employers and state welfare funds, or under any other benefit plan, for this period of care. I request that payment of authorized benefits be made on behalf of the patient directly to the said physicians, and sleep center and to any appropriate agents or divisions.

B. **Release of Medical Information:**
The undersigned agrees to the release of medical information to referral sources to facilitate communication between facilities that have and may provide care and to assist in the discharge process.

C. **Financial Agreement:**
The undersigned agrees, whether he/she signs as an agent or as patient, that in consideration of the services to be rendered to the patient, the patient is hereby obligated to pay the account of the sleep center in accordance with the regular rates and terms of the physician(s) and the sleep center. Should the account be referred to an attorney or collection agency for collection, the patient shall pay actual attorney's fees and collections expenses. All accounts shall bear interest at the legal rate.

D. **Insurance Policy:**
I hereby authorize my insurance company to furnish all copies of my insurance policy to the physician(s) and the sleep center.

_____ _____
Patient's Signature Patient Representative (if patient is unable to sign)

_____ _____
Insured Policyholder's Signature Patient Representative's Relationship to Patient

_____ Time of Signing _____ _____ _____ _____ a.m. p.m.
Date Month Day Year Hour

I have read and/or explained the above information and all parts of this form outlining all stated conditions to the patient's legal representative and the patient/responsible party appears to fully understand these conditions as stated.

_____
Signature of Sleep Center Representative