Sleep Disorder Center

Patient Information

Name_____

Address_____

City_____

Home Phone _____

Cell Phone_____

DOB_____ Sex M ___ F ___

Marital Status S ___ M ___ W ___ D ___ SEP___

Social Security_____

Employer_____

Work Phone_____

Driver's License_____

Email_____

Responsible Party Information

Name_____

Address_____

City_____

Home _____Cell_____

Social Security_____

DOB_____ Sex M ___ F ___

Employer_____

Work Phone_____

Emergency Contact

Name_____

Relationship_____

Home_____Cell_____

Primary Insurance

Insurance Company_____

ID #_____

Subscriber_____

DOB_____SS#_____

Relationship to patient_____

Secondary Insurance

Insurance Company_____

ID #_____

Subscriber_____

DOB_____SS#_____

Relationship to patient_____

_____ _____ _____

Patient/Parent/Guardian Signature **Relationship to Patient** **Date**

Direct Insurance Payment

In the event that my insurance company issues a check in to me directly and/if the check is payable to the person insured for the services rendered to me by Oxnard Sleep Disorders Center, Inc., I will, upon receipt, endorse the check to Oxnard Sleep Labs, Inc., by signing the back of the check and include "Pay to the order of Oxnard Sleep Disorders Center.

Patient's Signature: _____Today's Date: _____

Patient Authorization for Release of Medical Information

I, _____, give Oxnard Sleep Disorders Center, Inc. my permission to release information from my medical records to the following family member (s)/ friend (s) in my absence. This release will also apply to my referring physician(s) and/or their staff; any doctors and their staff who provide services to Oxnard Sleep Disorders Center, Inc., and any durable medical equipment company (DME) staff used to supply medical equipment to me for any recommended treatment. Unless otherwise noted this release allows the above entities to leave messages on my answering machine/voice mail, with whomever answers the phone numbers I have provided to Oxnard Sleep Disorders Center, Inc., and to call me at work.

Patient's Signature: _____Today's Date: _____

NAME	RELATIONSHIP
_____	_____
_____	_____

EXCEPTIONS: _____

Patient's Signature: _____Today's Date: _____

Policy and Patient Responsibilities

Patient Name: _____ If Minor, Parent/Guardian Name: _____

Insurance Plans PPO / Gold Coast Health Plan / Clinicas/ Medicare: Your insurance card must be provided at time of service. You are responsible for payment for services whether or not it is covered by your insurance.

Deductible: It is your responsibility to pay at the time of service until your deductible amount, set by your insurance carrier, has been met or prior arrangements have been made with our billing department.

Cash/Self-Pay: Payments are to be made in full at the time of service unless specific payment arrangements have been made with our billing department prior to your appointment.

Missed Appointments: Our office has a **72 hour CANCELLATION POLICY**; it is your responsibility to call us if you are not able to keep your appointment. You will be charged $250 for any missed appointments.

Returned Checks: We have a $35 FEE which will be charged for any returned checks.

Delinquent Accounts: Will be reported to a collection agency after 60 days.

Release of Medical Records: A fee will be charged for the copying and releasing of any patient medical records. $28 if the records are to be mailed and $25 if they are going to be picked up.

Minor Patients (under the age of 18): Per California law, all minors must be accompanied by a parent or guardian for service at our sleep center. If the parent of guardian cannot be present, written authorization for service must be given prior to appointment.

ACKNOWLEDGEMENT:I HAVE READ AND UNDERSTAND Oxnard Sleep Disorders Center, INC'S PRIVACY NOTICE AND POLICIES

Patient or Guardian Signature: _____ Date:_____

Patient Service Agreement and Plan of Service- Sleep Testing

Patient Name: _____ **ID** _____

Authorization/Consent for Care/Service: I have been informed of the selection of providers from which I may choose. I authorize Oxnard Sleep Disorders Center under the direction of the prescribing physician, to provide sleep technology services as prescribed by my physician.

Assignment of Benefits/Authorization for Payment: I hereby assign all benefits and payments to be made directly Oxnard Sleep Disorders Center for all services furnished to me in conjunction with my care. I authorize Oxnard Sleep Disorders Center to seek such benefits and payments on my behalf. It is understood that, as a courtesy. Oxnard Sleep Disorders Center will bill Medicare/Medicaid or other federally funded sources and other payers and insurer(s) providing coverage, with a copy to Oxnard Sleep Disorders Center I understand that I am responsible for providing all necessary information and for making sure all certification and enrollment requirements are fulfilled. Any changes in the policy must be reported to Oxnard Sleep Disorders Center within 30 days of the event. I have been informed by Oxnard Sleep Disorders Center of the medical necessity for the services prescribed by my physician. I understand that in the event services are deemed not reasonable and necessary, payment may be denied and that I will be fully responsible for payment.

Release of Information: I hereby request and authorize Oxnard Sleep Disorders Center, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Oxnard Sleep Disorders Center, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize Oxnard Sleep Disorders Center to review medical history and payer information for the purpose of providing services.

Financial Responsibility: I understand and agree that I am responsible for the payment of any and all sums that may become due for the services provided. These sums include, but are not limited to, all deductibles, co-payments, out-of-pocket requirements, and non-covered services. If for any reason and to any extent, Oxnard Sleep Disorders Center does not receive payment from my payer source, I hereby agree to pay Oxnard Sleep Disorders Center for the balance in full, within 30 days of receipt of invoice. All charges not paid within 45 days of billing date shall be assessed late charges. I am liable for all charges, including collection costs and all attorneys cost. I am responsible for all charges regardless of my payer unless my agreement with my health plan holds me harmless.

_____ **(Initials) I acknowledge that I have been advised of my financial obligations to Oxnard Sleep Disorders Center.**

Patient Handouts: I acknowledge that I have received a copy of the Patient Handouts which contains Patient Rights and Responsibilities, HIPAA Privacy Standards and Complaint/Grievance Reporting. I acknowledge that the information in the Patient Handouts has been explained to me and that I understand the information. I acknowledge that I have received sleep lab marketing material and information on the sleep lab's scope of services.

Grievance Reporting: I acknowledge that I have been informed of the procedure to report a grievance should I become dissatisfied with any portion of my experience. I understand that I may lodge a complaint without concern for reprisal, discrimination, or unreasonable interruption of service. To place a grievance, please call (805) 667-8049 and speak to customer services. If your complaint is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Governing Body. You can expect a written response within 14 working days or receipt.You may also make inquiries or complaints about this sleep lab by calling 1-800-MEDICARE and/or the Accreditation Commission for Health Care (ACHC) at 919-785-1214**.**

PLAN OF SERVICE

Identified Needs/Problems:
The patient is or may be unfamiliar with Sleep Disorders and Sleep Studies to diagnose Sleep Disorders,
The patient may require follow-up services.

Expected Outcomes:
The patient will be provided sleep testing to comply with the physician's prescription/orders.
The patient will communicate to the staff any questions and concerns.
The patient will know how to obtain follow-up services as needed.

Services/Actions Provided:
Perform patient assessment and perform ordered testing.
Provide Sleep Disorder Education.
Provide written handout for Patient Bill of Rights and Responsibilities, HIPAA Privacy Standards and Grievance Reporting
Provide written instructions for obtaining follow-up services.

Patient: _____ **Date:** _____

Witness: _____ Date: _____