SLEEP DISORDER CENTER

502 East Pine Ave Crestview, FL 32539
111 Bailey Drive Suite 2 Niceville, FL 32578
8734 Ortega Park Drive Navarre, FL 32566
151 Mary Esther Blvd, Suite 203 Mary Esther, FL 32569
(850) 689-5496 ● (850) 243-4456 ● (850) 279-4442 ● (850) 936-4717 ● Fax: (850) 689-5497

Insurance and Financial Information Release of Information

_____ Patient / Beneficiary

Signature on file agreement: I request that payment of authorized Medical Benefits be made to the Sleep Disorder Center, for any services furnished to me by "The Sleep Disorder Center of Ft. Walton Beach, Inc." herein referred to as "The Center".

Advanced Notice: Your insurance company or Medicare, where applicable, will only pay for services that it determines to be "reasonable and necessary" under section 1862 (A) (1) of the Medicare law. If your insurance or Medicare determines that a particular service, although it would otherwise be covered is "not reasonable and necessary" under program standards, your insurance company or Medicare will deny payment for the service (polyomnography) provided for the following reasons: the patient did not complete 6 full hours of testing, the patient did not have symptoms consistent with OSAS (snoring, daytime sleepiness, or fatigue etc.). Medicare and other insurance will also deny coverage for CPAP/ Bilevel titration for insufficient RDI on Ploysomnography.

Authorization to Release Medical Information: I hereby authorize the release of any medical information to be given to or received from The Center which is necessary to process any insurance claim for the person named herein (this includes Social Security Administration, its intermediaries, and insurance carries for Medicare patients).

Assignment of Insurance Benefits: I hereby assign to and authorize payment directly to The Center of all benefits payable under the terms of Medicare or any insurance policy or benefits (not applicable when payment is made).

Financial Responsibility: I understand that I am financially responsible to The Center for all legal charges incurred by the person(s) named herein. In the event that this account is placed in the hands of an attorney for collection, the patient and/ or guarantor, jointly and separately agree to pay all costs of collection which include but are not limited to interest at the highest legal rate, attorney fees and court costs.

I understand and consent to being recorded (both audio and video) for the purpose of this study.

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Beneficiary/ Responsible Party (Guarantor) Date