ASHTABULA SLEEP MEDICINE

Patient Registration Form

Patient Demographics

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Name: _____ ID#: _____ GRP#: _____

Secondary Insurance Name: _____ ID#: _____ GRP#: _____

Assignment of Benefits/Statement of Financial Responsibility

I, the undersigned, hereby request payment for authorized insurance benefits be made on my behalf to Ashtabula Sleep Medicine, LLC for services and equipment provided by the organization. I assign and convey directly to Ashtabula Sleep Medicine, LLC as my designated authorized representative, all medical benefits and insurance reimbursement otherwise payable to me for all services, therapy, and equipment provided by the organization, regardless of managed care network participation status.

I understand that I am financially responsible to the organization for any changes not covered by health care benefits, in or out of network. I confirm that the insurance information above, for both primary and secondary insurance, is correct, and it is my responsibility to notify the organization of any changes in my healthcare coverage. In some case, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I acknowledge that I have been provided a copy of the Explanation of Fees and that bases on information from insurance company my estimated responsibility will be $_____, but I understand that this is not a guarantee. I understand by signing below that I am accepting financial responsibility for all payment for products and/or services received.

I understand that once the custom oral appliance device is fabricated, even if I chose to not receive or use the device, the product and service is still being rendered, a claim will be submitted to my health care insurer, and I will be financially responsible as outlined above.

Initial _____

ASHTABULA SLEEP MEDICINE

Medical Release

I, the undersigned, authorize Ashtabula Sleep Medicine, LLC to use and disclose my health information for the purpose of treatment, obtaining payment, or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to my ordering physician, dentist and the DME provider.

Acknowledge of Receipt of Privacy Practices

By signing the below, I acknowledge that I have been provided a copy of Notice of Privacy Practices.

General release of Liability and Assumption of Risk

I, the undersigned, understand that failure to comply with treatment of sleep apnea can result in physical and social issues including but not limited to: coronary artery disease, congestive heart failure, diabetes, hypertension, stroke, increased motor vehicle accidents, and excessive sleepiness.

As Ashtabula Sleep Medicine, LLC cannot ensure success of any treatment or guarantee that any patient will comply with treatment, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for damage, physical or monetary, that I might sustain as a result of my treatment or my failure to comply with treatment of sleep apnea. Therefore, I release the organizations, their affiliates, their employees, and their contractors, from any and all liability associated with my treatment and I personally assume all risk associated with my care.

I hereby agree to hold these organizations, their affiliates, their employees, and their contractors harmless for any damages that might result from my sleep apnea treatment.

Patient Signature:

_____ Date: _____

Print Name: _____