ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Comprehensive Sleep Center, PC of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the charges of Comprehensive Sleep Center, PC for these services. I understand that I am financially responsible to Comprehensive Sleep Center, PC for all charges whether or not it is covered by my insurance company. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: For services furnished by Comprehensive Sleep Center, PC, I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services, I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fees and court costs.

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, the nurse or staff. I understand that office practice are available only for out-patient care between 8 AM to 5 PM, Monday-Friday.

AUTHORIZATION FOR RELEASE OF INFORMATION: I understand that my information may be given to the insurance company with whom I have coverage, agencies which may be assisting with payment for my care, billing agencies, agencies responsible for reviewing payments and/or quality of care, and other governmental agencies. I give permission for release of this information.

NO SHOW POLICY: Comprehensive Sleep and Breathing Disorders Center, P.C. has a $30.00 fee for missed appointments. As a courtesy, reminder calls are made 2 business days before a visit. Please do not depend on the reminder call to confirm your visit as this service may not be possible every day. It is your responsibility to remember your visit.
If you cannot keep your scheduled visit you need to contact us 24 hours prior to cancel or reschedule. If you miss your visit, **you will be charged $30.00** for the missed visit. This is not billable to your insurance and is an out-of-pocket expense to you. Please be advised this is a change from our previous policy. Patients are required to be notified of this fee.

By signing below, you agree to the terms noted above.

PATIENT SIGNATURE: ______________________________ **DATE:** ________________

PATIENT NAME (PRINTED): ______________________________