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Phone: (609) 490- 1444
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CMD
Sleep Disorders Center

Billing and Insurance Acknowledgement

Please review and initial that you acknowledge and agree to the following statements.

Medicare Acknowledgement:
I request that payment of authorized Medicare benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I authorize any holder of medical information about me to be release to “The Centers for Medicare & Medicaid Services”, and its agents any information needed to determine these or the benefits payable for related services. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. ___________ (Initials)

Commercial Insurance Acknowledgement:
I request that payment of authorized Health Insurance benefits be made either to me or to [Comprehensive Medical Diagnostics, LLC] for any services furnished to me. I understand that I will be responsible for any deductible, coinsurance, and non-covered expenses. Any payments made to me by my insurance company for services rendered at [Comprehensive Medical Diagnostic, LLC] will be mailed to the sleep lab (address on header). __________ (Initials)

I authorize [Comprehensive Medical Diagnostics, LLC] to release all medical information necessary for processing insurance claims to the insurers on file. I agree these provisions will be in effect until otherwise revoked by me. __________ (Initials)

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, and etc. I specifically authorize such healthcare providers to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other reports or information regarding my physical condition. __________ (Initials)

Acknowledgement for SELF-PAY:
You have requested that this service to be self-pay because (initial one):
____You have no health insurance.
____You have health insurance, but you do not want your insurance billed and instead want to pay out of pocket.
____ Other (Please Explain): ____

NO SHOW
_____ I understand that sleep lab may charge a $200 “no show” fee in the event that I do not call with at least 24 hours’ notice to cancel or reschedule an appointment.

By signing below, I acknowledge that I have read and understand the above information. I confirm that I am the patient, or the patient’s duly authorized representative.

Signature of Patient or Legal Representative: ____ Date: ________________

Print Name: ____ Relationship to Patient: ________________