Valley Sleep Center
A Night and Day Difference!

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
ACCREDITED FACILITY MEMBER

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Valley Oximetry, Inc. as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care.
- Your insurance is a contract between you and your insurance company. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your coverage. This includes all primary, secondary and any tertiary coverage.
- Patient (or patient's guardian) is responsible for payments of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Co pays are due at the time of service.
- Coinsurance and deductibles are due at the time of service. This charge is an estimate of what your insurance carrier covers. Patients may incur, and are responsible for payment of any additional charges, if applicable. This includes any charges that are not covered by any secondary or tertiary insurance.
- We expect and encourage that you know your insurance benefits, including but not limited to co payments, coinsurance, deductibles and services that are covered or not covered by your carrier. All out of pocket amount s quoted by Valley Oximetry, Inc. are estimates. Prior approvals that are received from your insurance company are not a guarantee of payment.
- The patient (or patient's guardian) is required to provide a copy of your insurance card(s) and photo ID. Additionally, a Credit/Debit Card may be required to be kept on file for guarantee of payment(s) or cancellation fees.
- A cancellation/no show fee of $50.00 will be charged if you do not notify us at least 24 hours prior to your scheduled consultation appointment or your scheduled DME set up. You must notify us at least 48 hours prior to your scheduled Sleep Study or there will be a $200.00 cancellation fee. The notification must be business days which are Monday through Friday. Please contact us at (480)830-3900 or email: sleep@valleysleepcenter.com
- Patient statements are mailed monthly. Payments for invoices that are billed to the patient are due 30 days from receipt of billing. A $25.00 fee will apply if payments are late. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement. A service charge will apply for any payment arrangements.

I hereby assign my insurance benefits to be paid directly to Valley Oximetry, Inc. I also authorize Valley Oximetry, Inc. to release any information required to process claims or required in the course of my treatment. By signing this document, I state that all information given is accurate and true. I further acknowledge that I have read, understand and agree to the provisions of this Patient Financial Responsibility Form.

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Patient/Legal Representative or Parent/Legal Guardian Printed Name Date

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Patient/Legal Representative or Parent/Legal Guardian Signature Date