Sleep Disorders Center of Alabama

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Your office visit co-pay is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. Payment for co-insurance (i.e. 20%) and deductibles are due upon receipt of your first statement.

As a courtesy, we will process and file your insurance claims for technical and professional services for you at no cost.

Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY <u>BEFORE</u> SIGNING

Signature:_____ Date:_____

(Patient and/or Responsible Party)