Valley Regional Sleep
Disorders Center

Date of Service: ________________ SDC #: ________________

FINANCIAL POLICY

Dear Patient:

Thank you for choosing the Valley Regional Sleep Disorders Center as your health care provider. We are committed to the goal of providing the highest quality of care possible for the evaluation and treatment of your sleep related problem. We realize that the high cost of quality medical care is a concern of all recipients of healthcare today. In light of these concerns, we feel it is important that we provide a clear explanation of our financial policy and encourage you to discuss any questions or concerns you may have with our business office. It is hoped these explanations will help to eliminate any confusion or misunderstanding regarding our billing practices.

You should be aware that the total charges for your evaluation will consist of:

1. Professional fees billed by MD/PhD – These generally include your initial consultation, sleep study interpretations and follow-up visits with the doctor.

2. Sleep center services billed by the Valley Regional Sleep Disorders Center Billing Office (if a sleep evaluation is ordered).

Services provided by the sleep center are generally covered by most insurance policies. We will process your claim for insurance reimbursement if you provide us with the necessary insurance information and forms. However, it should be understood that all charges are the responsibility of the patient. Our billing office will estimate and request payment for your deductible and "co-pay" amounts once services have been provided. If payment arrangements are needed, we would ask that you contact our billing office. On occasion, some insurance companies may select certain services they will not cover or cover at a lesser percentage. In most cases we will provide reasonable assistance in challenging seemingly inappropriate insurance allowances.

We wish to thank you for the opportunity to serve your medical needs.

Sincerely,

Lynn Carter
Administrative Director

I acknowledge that I have read and understood the financial policy described above.

____
Patient, Guardian or Legal Representative Signature Date

____
Witness Signature Date