Red River Sleep Center, Inc.

Patient Financial Acknowledgement and Consent

Patient Name ___________________________________ **DOB** ________________

Name of Insurance Policy Holder ___________________________________ Relationship ________________ DOB ________________

Social Security Number of Policy Holder _____________________________

Insurance card/information must be provided prior to signing this form.

I hereby instruct and direct my Insurance Company, as indicated by the insurance card/information I provided to Red River Sleep Center, Inc. to pay by check/Credit Card/EFT **Or** if my current policy prohibits direct payment to my doctor/service provider, to make the check to me to be mailed to any of the following providers: Paul A. Guillory MD, Renick P. Webb MD, Red River ENT & Associates and/or Red River Sleep Center Inc., for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee(s), and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize that my doctor and/or the service provider may release a copy of my sleep reports to the physicians I have listed on the front of this form. I authorize my doctor and/or the service provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance) I am ultimately responsible for the balance of my account for any professional services rendered. I understand that this includes covered and non-covered services/charges. I have read and completed all the information on both sides of this sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

By signing below I understand that, as a courtesy, Red River Sleep Center, Inc. will be contacting my insurance to verify benefits concerning coverage of the services expected to be received. I understand that this is not a guarantee of payment by my insurance. Decisions about payment are made by the insurance company once the claim is received. Benefits and payment are based on review of the patient's contract with the insurance company and are decided at the time the claim is reviewed by the insurance company. I understand that I am responsible for contacting my insurance company and verifying the benefits for services to be performed. I also understand that I am financially responsible for all charges due to Red River Sleep Center, Inc. based on services received regardless of payment by insurance. It is my responsibility to make sure my coverage is active and up-to-date. I understand that I am to inform Red River Sleep Center, Inc. of any changes in my policy or changes in insurance coverage. I understand that if my insurance company fails to pay a claim within six months of being filed by Red River Sleep Center, Inc., that I am responsible for the charges in full.

_____________________________________ ________________

Signature of Patient or Representative **Date**

DISCLOSURE OF FINANCIAL INTEREST

As Required by R.S. 37:1744 and LAC 47:XLV.4211-4215

Louisiana law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest. Renick Webb, MD and/or Paul Guillory, MD may be referring you, or the named patient for whom you are the legal representative to: Red River Sleep Center, Inc. - 223 Windermere Blvd. - Alexandria, LA 71303 to obtain a diagnostic procedure or received home medical equipment. Renick Webb, MD and/or Paul Guillory, MD have a financial interest in Red River Sleep Center, Inc. The nature and extent of the financial interest is that these physicians own the Red River Sleep Center, Inc.

PATIENT ACKNOWLEDGEMENT

I, the above named patient (or a legal representative of such patient), hereby acknowledge receipt, on the date indicated and prior to the described referral, a copy of the foregoing Disclosure of Financial Interest.

_____________________________________ ______________________

Signature of Patient or Representative **Date**