ASCENT HEALTHCARE SOLUTIONS FINANCIAL POLICY

PATIENT NAME: _____ PATIENT D.O.B: _____/_____/_____

We thank you for choosing ASCENT HEALTHCARE SOLUTIONS hereinafter referred to as Ascent Sleep & Weight, as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form top acknowledge your understanding of our patient financial policies.

In lieu of all insurance carriers' claim that the "quotation of benefits is not a guarantee of payment" the patient (or patient's guardian, if a minor) is ultimately responsible the payment of his or her treatment.

It remains the patient's responsibility to let ASCENT SLEEP & WEIGHT know before the time of service if their insurance policy has changed, terminates or has been discontinued for any reason. If the insurance policy has been terminated at the time of service for any reason, the patient will be financially responsible for 100% of the charges. It is your responsibility as the patient to provide us with the, most correct and updated information about your insurance and will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment of co-pays, co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service and for your convenience; we accept cash, check and all major credit cards at our office and lab locations. Patients may incur and are responsible for the payment of additional charges at the discretion of Ascent Sleep & Weight. These charges may include (but are not limited to): Charge for returned checks, charge for missed sleep study appointments without 48 hours advance notice (48 hours from 5.00pm, on the scheduled date of the appointment) and any costs associated with collection of patient balances.

I have read the above policy regarding my financial responsibility to Ascent Healthcare Solutions for providing healthcare services to me or the above named patient. I certify that the financial information I have provided is true and accurate. I authorize my insurer to pay any benefits directly to Ascent Healthcare Solutions, the full and entire amount of bill incurred by me or the above named patient, or if applicable any amount due after payment has been made by my insurance carrier.

Please be advised that it remains the patient's responsibility to let us know at the time of service if the insurance policy as changed or has been termed for any reason. If insurance policy has been termed at the time of service for any reason patient will be financially responsible for 100% of the charges.

Patient's Signature: _____ Date: _____

Guarantor's Signature: _____ Date: _____

(*If Guarantor is not the patient*)