

Patient Registration Form

Patient's Legal Name (last, first, middle)		Sex	Date of Birth	Marital Status
Email Address	Home Phone	Business Phone		Other Phone
Address, City, State, Zip				
Emergency Notification	Relationship	Home Phone	Other Phone	

Insured's Legal Name if different from patient (last, first, middle)		Relationship to Patient	Date of Birth
Social Security Number	Home Phone	Business Phone	Other Phone
Address, City, State, Zip (if different from above)			
Employer Name			Employer Phone
Primary Insurance Company Name		ID Number	Group Number
Mailing Address, City, State, Zip			Benefits Phone Number
Secondary Insurance Company Name		ID Number	Group Number
Mailing Address, City, State, Zip			Benefits Phone Number

Insurance Policy:

Payments of our fees are your responsibility and are due in full at the time of service. As a courtesy to you, we will verify benefits and file our charges with your insurance carrier. The guarantor and/or patient agrees to:

1. **Verification of coverage and benefits is not a guarantee of payment.**
 - **The information provided to us by your insurance company may be inaccurate. It is the patient's responsibility to clarify this information directly with their insurance company.**
2. Pay any portion of our fees that are not covered by the insurance company, excluding contracted rates.
3. Respond to requests from their insurance company for additional information in order to process claim(s).
4. Monitor claims filed with the insurance company by reviewing the "Explanation of Benefits" (EOB's) received from the insurance company, and by calling to check the status of outstanding claims.

Out of Network with Your Health Insurance Plan

If we are not a participating provider ("Out of Network") with your health insurance plan, please call your insurance company to clarify your out of network benefits. Please understand that insurance carriers have established usual and customary fees for reimbursement. Since we are not a contract provider with your insurance company, our standard fees may not be consistent with the usual and customary fees established by your insurance company.

Financial Agreement/Assignment of Benefits:

As the responsible party (guarantor and/or patient), I hereby assign to Sleep Medicine Associates of Texas, P.A. (physician practice), any and all payments of health insurance benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. If my condition was caused by events, which result in legal action, I assign to the physician practice an interest in any claims I may have. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment; I understand I am financially responsible for all health insurance deductibles, co-payments, coinsurance, and any services not covered by my insurance policy. I also agree to accept the terms of the above listed Physician Practice Insurance Policies.

Signature of Guarantor and/or Patient

Date