Siouxland sleep solutions

PATIENT NAME _____ **DOB** _____

Please read the following, sign and date at the bottom. Thank you

I acknowledge that I have received the Notice of Privacy Practices.

I understand that I am financially responsible to pay Siouxland Sleep Solutions its usual charges for all services rendered. This may include any balances not covered by my insurance carrier(s). I hereby assign all my rights to receive any and all insurance proceeds, otherwise paid to me, for coverage(s) provided by my health insurance carrier(s) to Siouxland Sleep Solutions and direct that payment of proceeds be made directly to Siouxland Sleep Solutions.

I authorize the release of medical record information or excerpts thereof to any insurance company or third-party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to the authorization.

To be in compliance with federal guidelines, we are required to submit your medical records (or your child's) to your requesting physician. Please be advised that Siouxland Sleep Solutions may release your medical records (or your child's) to your family physician, requesting physician and to any facility in which further testing, or surgeries may be performed.

This authorization will remain in effect for one year from signature date unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

Responsible Party:

SIGNATURE_____**DATE**_____

Printed Name of Responsible Party (if different from patient):

_____**Relationship:** _____