ANCHORAGE SLEEP CENTER
510 W Tudor Rd Ste 5
Anchorage, AK 99503
(907) 743-0050 *phone*
(907) 743-0060 *fax*

WASILLA SLEEP CENTER
3719 E Meridian Lp Ste C
Wasilla, AK 99654
(907) 357-4200 *phone*
(907) 357-4201 *fax*

FAIRBANKS SLEEP CENTER
475 Riverstone Way #1
Fairbanks, AK 99709
(907) 374-9920 *phone*
(907) 374-9930 *fax*

SOUTHEAST SLEEP CENTER
2223 Jordan Ave
Juneau, AK 99801
(907) 500-7368 *phone*
(907) 500-7386 *fax*

PENINSULA SLEEP CENTER
43335 Kalifornsky Beach Rd Ste 25
Soldotna, AK 99669
(907) 420-0600 *phone*
(907) 420-0610 *fax*

GENERAL POLICIES

Anchorage Sleep Center, LLC offers sleep diagnostic and treatment services for patients across Alaska, with direct presence in Anchorage, Fairbanks, Wasilla, Juneau and Soldotna, and remote services for patients in other locations. We are committed to delivering state-of-the-art sleep medicine care in a pleasant and comfortable environment, with courtesy and attention to patients' individual needs and in close collaboration with referring providers. We take pride in being your chosen provider and encourage your feedback as we strive to provide the highest quality of service and care to our patients. Prior to becoming our patient, it is important that you review and understand our general and financial policies and provide complete information as requested in the enclosed patient registration forms.

CONSENT TO MEDICAL TREATMENT

I, the undersigned, hereby consent to and permit Anchorage Sleep Center, LLC, its providers, employees, and other persons caring for me (or the patient listed below) to provide treatment, diagnostic procedures and other health and medical services as may be deemed necessary and available to me (or the patient listed below) during the period of care. I understand that the patient care is under the control of healthcare providers who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me (or the patient listed below) as to the result of examination or treatment at Anchorage Sleep Center, LLC. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

PATIENT'S RIGHTS

You have the RIGHT to:

- Receive accurate and easily understood information about the patient's proposed health care and the providers of such care. If the patient speaks another language, has a physical or mental disability, or just doesn't understand something, help should be given so that the patient can make informed health care decisions.
- Know treatment options and take part in decisions about care. Parents, guardians, family members, or others can speak for the patient, if the patient cannot make his/her own decision.
- Receive considerate, respectful care from doctors and other healthcare providers that does not discriminate against the patient.
- Talk privately with healthcare providers and to have healthcare information protected.
- Read and copy your own medical record and ask that your doctor change the record if it is not correct, relevant, or complete.
- Examine and receive a detailed explanation of any medical bill and the information regarding financial assistance that may be offered.

PATIENT'S RESPONSIBILITIES

You have the RESPONSIBILITY to:

- Provide your current health insurance details, including primary, secondary and tertiary coverage, and promptly report any change or termination of your health insurance coverage.
- Provide Anchorage Sleep Center, LLC with any change in demographic information.
- Provide, to the best of your knowledge, accurate and complete information concerning your medical history, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Tell your doctor about any change in your condition or if problems arise.
- Tell your doctor if you do not understand your treatment or what you are expected to do.
- Accept financial responsibility for payment of services, pay your bill promptly or inform Anchorage Sleep Center, LLC if you are unable to pay your bill.
- Follow the recommended plan of treatment or assume responsibility for your actions if the treatment is refused.
- Adhere to the office rules, be respectful to other patients and staff, be considerate of their rights and personal property and the property of the clinic.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

By signing below, I acknowledge that I have reviewed and agree to the Anchorage Sleep Center, LLC's Notice of Privacy Practices that describes how my (or the patient's health information) is used and shared. I understand that I am entitled to receive a copy of the Anchorage Sleep Center, LLC's current Notice of Privacy Practices at any time.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Anchorage Sleep Center, LLC to disclose all or any part of my record, and any other information in its possession, to any other parties related to my care, including, but not limited to, insurance companies and worker's compensation carriers. I hereby release Anchorage Sleep Center, LLC from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Anchorage Sleep Center, LLC to furnish requested information excerpts from my record to any insurer, its intermediary or another healthcare facility to provide continuity of care. Anchorage Sleep Center, LLC may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Anchorage Sleep Center, LLC keeps a record of the health care services provided and that I may review my record (a 24-hour notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Anchorage Sleep Center, LLC to correct that record. Except as noted above, Anchorage Sleep Center, LLC will not disclose my record unless I direct them to do so, or the law authorizes or compels them.

CANCELLATIONS AND MISSED APPOINTMENTS

Our office schedules appointment times specifically for you. If you must reschedule or cancel your appointment, please contact our office at least 24 hours in advance. A cancellation fee of $50.00 for day-time appointments and $250.00 for in-lab sleep studies may be charged for late cancellations or appointments missed without prior notice. This charge is NOT billable to your insurance payer and is the responsibility of the patient (or guarantor) to pay. Multiple short-notice cancellations may result in our inability to schedule future appointments. All scheduling matters should be directed to the individual offices: Anchorage 907-743-0050 / Wasilla 907-357-4200 / Fairbanks 907-374-9920 / Southeast 907-500-7368 / Peninsula 907-420-0600 during normal business hours Mon-Fri 9:00am – 5:00pm.

WAITING LIST FOR SERVICES

If you would like to schedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment or additional dates and times become available, we will contact patients on the waiting list on a first-come-first-serve basis.

CONSENT TO RECORD AUDIO/VIDEO FOR INLAB SLEEP TESTING

I understand that during the course of my sleep study, I may be video/audio taped by the sleep technologist. I hereby authorize the use of this video/audio for the sole purpose of medical diagnosis and treatment. This video will NOT be distributed or shared for any purpose, unless requested under applicable law.

PHOTOGRAPHS

The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment at Anchorage Sleep Center, LLC for purposes of scientific and medical study and research is approved, provided my identity is not revealed. Photographs may include the use of video tapes and television.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your caregiver experience a situation that requires the attention and resolution of a supervisor and/or manager, please contact our practice either by phone or in writing. Our Manager/Business Owner will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Anchorage Sleep Center, LLC to provide me medical services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

FINANCIAL POLICY

Our practice participates with Medicare, Medicaid, and other healthcare insurance plans. As a courtesy to you, we will file insurance claims for services on your behalf. Patients are responsible for deductibles, co-payment and co-insurance amounts, non-covered services, and out-of-network services. For non-insured patients, please contact our staff to make payment arrangements.

Please be prepared to provide a current copy of your insurance and ID card(s) at each visit. It is the patient's responsibility to know and understand their insurance benefits and verify the in-network vs out-of-network status of the healthcare provider. If at any point your insurance policy changes, terminates or cancels coverage, you will be fully responsible for all charges that cannot be rebilled to the new insurance provided. Most insurance(s) have different requirements for prior-authorizations and timely filing requirements, and if they are not met, we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy.

Our Billing Department can obtain a general breakdown of your insurance benefits from your insurance carrier. This information can be provided to you upon request. This information is not a guarantee of benefits; all claims are subject to processing by the insurance and its medical guidelines and policies, pre-authorization requests, appeals, and various factors that are out of our control.

Our office accepts cash, checks, money orders and credit card payment. Following the receipt of your monthly patient statement, please contact our Billing Department if you need to discuss a payment arrangement. We are willing to negotiate reasonable payment plans to keep your account current.

If you have inquiries about your claims, monthly statements, other billing matters, or if you have healthcare coverage updates, please contact our Billing Department at 907-743-0080 Mon-Fri 8:00am-4:00pm.

WORKER'S COMPENSATION

If you are being treated for a work-related condition, please complete our worker's compensation verification form so that we may submit needed authorizations and claims on your behalf.

INTEREST CHARGES ON PATIENT BALANCES

Our practice charges interest on unpaid account balances. If we receive a payment on your account from either you or your healthcare insurance payer within 30 days, no interest charges will be applied to your account.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

AUTHORIZATION OF PAYMENT

I hereby authorize payment of medical benefits directly to Anchorage Sleep Center, LLC for services rendered to me during the period of my care. If my health insurance plan will not direct payment to ASC, I agree to forward to ASC all health insurance payments which I receive (or the patient receives) for the services rendered by ASC. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize the release of information as may be necessary for purpose of treatment, payment and operations such as credentialing, peer review, accreditation and compliance with state and federal laws. I authorize ASC to file an appeal on my (or the patient's) behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I permit a copy of this authorization to be used in place of the original.

MEDICARE AUTHORIZATION (For Medicare patients only)

I hereby request that payment of Medicare benefits be made on my behalf to Anchorage Sleep Center, LLC for services rendered to me by that physician, clinic or supplier. I authorize any holder of Medicare information about me to be released to the Centers for Medicare Services (CMS) and its agents, including information needed to determine the benefits payable for related services.

FINANCIAL AGREEMENT

By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Anchorage Sleep Center, LLC for the services provided to you.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Printed Name (Patient or Authorized Representative): _____