Advanced Sleep Therapy, LTD

Assignment of Insurance Benefits

I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by Advanced Sleep Therapy, Ltd. to Advanced Sleep Therapy Ltd. and authorize Advanced Sleep Therapy Ltd. to submit claims to Medicaid and commercial insurance carriers for payment. I authorize payment of my insurance benefits directly to Advanced Sleep Therapy Ltd., which may not exceed the balance due on my account. I hereby guarantee payment to Advanced Sleep Therapy Ltd. of any and all charges not covered by this assignment, and waive any and all notices and demands in the event of non-payment there under.
I am aware that Advanced Sleep Therapy Ltd. will bill me for my deductible and co-pay charges on equipment and/or supplies that I have rented or purchased. If my insurance denies payment, I agree to be personally and fully responsible for payment. I agree to pay any fees associated with collections if I fail to pay my bill in 90 days or make payment arrangements if payment in full is not possible.

I agree rental equipment remains the property of Advanced Sleep Therapy, Ltd. and will be returned in good condition if no longer necessary. Individual insurance company policies vary; however, some insurance companies require that we bill your "pap" equipment for 3 months as a rental and then convert it to a purchase in the 4th month. This 3 month rental period allows time for the patient to acclimate to the equipment and make sure that they are able to tolerate therapy. Other insurance companies "rent" the "pap" equipment for 10-13 month period. At the end of the rental period you own the equipment. Again, this allows for the patient to make sure they are able to tolerate the therapy. While AST verifies insurance benefits, it is the patient's responsibility to understand their insurance plan and direct any questions to their insurance carrier.

_____ _____
Signature of Patient Date AST Representative Date

Authorization for Disclosure

I, _____, authorize Advanced Sleep Therapy, Ltd. to use or disclose the personal health information listed below.
Sleep Therapy Reports and notes.

I also understand that the purpose of this use or disclosure is for the purpose of: Collaborating with your physician to improve the care you receive and for insurance billing.

I also understand that the personal health information listed above will be provided to: My physician and my insurance company when requested. Advanced Sleep Therapy, Ltd. authorized auditors for purposes of certification, licensure, or accreditation.

I understand this disclosure of information will NOT be used past: My relationship with Advanced Sleep Therapy, Ltd.

I understand that I may revoke this authorization for the use or disclosure of personal health information at any time, and that it must be in writing.

I acknowledge the receipt of the Notice of Information Practices.

_____ _____
Signature of Patient (or Legal Representative) Date

Better Sleep. Better Health.
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