

Vancouver Sleep Center



16219 S.E 12th Street • Vancouver, WA 98683 • Phone: 360-839-4532 • Fax: 360-838-0117

Web: www.vansleep.net

Conditions of registration.

Medical Consent:

I consent to the provisions of Healthcare Services at Vancouver sleep center and request my healthcare providers to provide any care they think is necessary and consistent with my instructions.

I understand the care may include tests, examinations, Image captures, and medical treatment. I acknowledge no guarantee has been made to me as to their results that may be obtained from the care.

I acknowledge that the health care providers treating me may be independent contractors, not employed by Vancouver Sleep Center.

I understand if special procedures or operations are needed, my healthcare provider will discuss this with me and my additional consent will be required.

I understand that if I undergo an in lab sleep study, continuous audio and video recording is part of the study.

Financial Agreement;

As a courtesy to you, our office will bill your insurance on your behalf for services rendered, provided complete and accurate information is provided at the time of each visit.

I understand copayments and/or deposits are required at the time of service.

I understand I am responsible for services not covered by my insurance or other agency, which may include deductible and co-insurance. If insurance payment is not received after 30 days, the balance becomes my responsibility. Accounts are payable in full at the time of billing.

I understand I will be charged a fee of \$25 for missed provider appointment.

I understand I will be charged \$10 if appointment is cancelled within 24 hours of scheduled appointment time.

I understand there is a \$150 charge for missed appointment to the sleep lab. I understand if this appointment is turned over to a third party collections agency, all services after that are deemed 'Cash only; and payable in full at the time of service.

I understand I will be charged \$35 service charge on all returned checks.

I understand if my insurance requires me to have a referral for services provided my Vancouver Sleep Center, it is my responsibility to obtain this.

Financial certification: I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

By signing below, I (patient or authorized consentor) hereby acknowledge I have read and fully understand the above information. I have asked questions about anything not clear to me and am satisfied with the answers received. I understand that I may revoke my consent at any time except to the extent that action has taken in reliance on such consent or authorization.

Signature:

Date