PULMONARY & SLEEP SPECIALISTS

# CONSENT OF TREATMENT

I,_____am authorizing and hereby give consent for the medical staff of Pulmonary, Critical Care and Sleep Specialist of Lake county to examine and render care

To: _____. This consent form will remain in effect until revoked in writing.

Signature: _____ Date: _____

Upon check-in, we will collect your deductible, co-pay, uncovered services, or percent of your responsibility. Please be prepared to pay **BEFORE** you are seen by the doctor.

Please be thorough with your insurance information if you expect us to file for you. Bring your card with you and your driver's license WITHOUT THESE WE WILL BE UNABLE TO SEE YOU!

As a courtesy, we will file your insurance. It is YOUR responsibility to make sure they are paying as they should.

If your insurance denies payment on your account, you will be asked to pay by check, cash, or charge. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge and turned over to collections. If you do not agree with the denial it is YOUR responsibility to pay services and take it up to your insurance company.

**TO ALL MEDICARE PATIENTS**: We will continue to participate as Medicare providers. We will bill your Medicare as well as secondary insurance, bit if payment is not received by your secondary insurance within 45 days you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office.

**SELF PAY PATIENTS**: This category includes those people with no insurance and patients who have and indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the services are rendered. We accept Visa, MasterCard, checks and money orders. If you will not be able to pay for our services in full you must contact the office to make a payment before coming to see the doctor.

If your insurance is out of state (except PPO insurance), you must pay for your visit at the time of service. 95% out of state insurance companies pay the patient and will not pay us directly (even if they tell you they will).

If you have any questions regarding this policy, please ask prior to being seen by the physician.

_____

(Print Name)

_____

Print Guarantor – (if different from patient name)

_____ Date: _____

Signature of Patient or Guardian/Parent