A logo with a tree in the middle

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**FINANCIAL POLICY**

**ASSIGNMENT OF RIGHTS AND BENEFITS**

**RELEASE OF MEDICAL AND PLAN DOCUMENTS**

Thank you for choosing us as your sleep care facility. Our goal is to provide you with the highest quality sleep care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. As with any other procedure done at a facility or hospital, we charge a fee to cover the cost of the sleep center’s study rooms, professional staff (technologists), technical equipment, supplies, etc. The purpose of this form is to notify you of your financial responsibility for our fee. As a courtesy, we will attempt to verify with your health insurer the benefits available to cover our fee and, as the assignee of your health insurance benefits, will bill your insurance and seek to collect those available benefits. We also are pleased to inform you that we may be able to offer you a discount on any outstanding amounts not covered by your insurance when your payment is made promptly in accordance with time periods set forth in the billing statement.

We ask you to read this policy carefully and sign prior to receiving our services. If you have any questions about this policy, we encourage you to bring them to our attention. Any questions concerning separate billing from other providers for their separate services in connection with your procedure should be directed to them.

ASSIGNMENT OF ALL RIGHTS AND BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS:

I understand and acknowledge that Pinon Sleep Center (collectively “the Center”) is an out-of-network provider for certain third-party payors.

In exchange for and in connection with any and all of the medical and related services provided to me (“Services”) by the Center, I hereby assign to the Center all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that I had, have or may have in the future pursuant to or in connection with any out-of-network insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively, “OON Health Coverage”).

This assignment includes, without limitation, authorization for my insurance carrier or health plan to pay by check made payable and mailed directly to:

**Pinon Sleep Center, LLC**

**PO Box 166**

**Farmington NM 87499**

In the event my insurance carrier or health plan sends payment for services rendered at the Center directly to me, I acknowledge and agree to endorse the back of the check or send a personal check for the total amount received from my insurance carrier or health plan. I understand and acknowledge that failure to remit the entire amount paid by my insurance carrier or health plan will result in immediate collection action for the full billed amount. In addition, if the Center is forced to take legal action in order to collect the facility fees, I understand and acknowledge that I will be responsible for the fees incurred by the Center to collect said facility fees.

This assignment also includes appeal rights (both internal and external), fiduciary rights, rights to release any medical or billing records, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, rights to insurance policy and/or settlement information and rights to notices and disclosures from any source (collectively, “Rights”). I am hereby transferring to the Center all of these Rights under any OON Health Coverage to which I am now, previously, or may be entitled to in the future with respect to the Services. Unless otherwise agreed between me and the Center, this assignment is irrevocable.

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY: I understand that, as a courtesy to me, the Center will file a claim with my insurance company on my behalf. However, I understand and agree by signing below that I am financially responsible for, and hereby do agree to pay, in a timely manner, charges not covered under my insurance or any balance not covered by the insurance payment. I understand that the Center reserves the right to require that I pay any unmet deductible or co-payment required by my OON Health Coverage or other deposit prior to services. I understand that the Center makes no guarantees that my insurance will cover any or all of the Services, and that I am not relying on any representations by the Center regarding the amount of plan benefits applicable to the Services prior to the claim being processed by insurance. I acknowledge that I have had a reasonable opportunity to inquire about the Center’s charges and that my questions regarding its charges, including any questions regarding a reasonable estimate of the total amount of the charges, have been answered. I understand that I may also be receiving separate bills from my durable medical equipment company (DME) for their services, and that any questions about their bills should be directed to them.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE: I hereby designate the Center and/or its designated agents and representatives as my duly authorized representative(s) in connection with all matters arising from or relating to Rights and OON Health Coverage, such that the Center completely and without reservation “stands in my shoes” and takes my place for all applicable purposes, and is granted absolute power and legal authority to seek, claim and directly receive payment or reimbursement for Services; challenge or appeal any adverse benefit determination of any kind whatsoever; or take any other action or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Rights in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedures or entitlement. I further authorize the Center and/or its designated agents and representatives to use my signature below on all correspondence, insurance and/or employee health benefits claim submissions relating to Rights and OON Health Coverage.

AGREEMENT TO COOPERATE: I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by the Center to effectuate, perfect, confirm, validate, or enforce my Assignment of Rights and Benefits to the Center or authorization of the Center as my authorized representative, as provided above. In the event that my insurance plan pays me directly for the Services, then I will immediately forward such payment to the Center with an endorsement and annotation: “Pay to the Order of

**Pinon Sleep Center, LLC**.”

If it becomes necessary for the Center to file a formal collection action against me, I agree to pay all costs, including reasonable attorney’s fees, incurred by the Center in the collection of the outstanding fees. I promise to make my best efforts to assist and to cooperate with the Center as needed or reasonably requested by the Center in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by the Center in order to exercise, secure or enforce any Rights.

A photocopy of this Financial Policy and Assignment of Rights and Benefits is to be considered as valid as the original. This lifetime assignment will remain in effect until revoked by me in writing. I have read, understand and fully agree to this Financial Policy.

**X**

Signature of Patient (or Guardian/Person Assuming Financial Responsibility) Date

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Name of Patient

Name of Guardian or Person Assuming Financial Responsibility, *if applicable*