SLEEP & LUNGS

Dr. Naga Chigurupati M.D.

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Financial Payment Policy

I hereby assign, transfer, and send over to Sleep & Lungs all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by insurance.

I am aware payment is expected at the time of service. Insurance information on file will be billed first. It is my responsibility to provide Sleep & Lungs with changes to or updates in my insurance coverage. In the event insurance coverage changes and/or an insurance carrier determine the billed services are not covered, it is my responsibility to contact the insurance company to clear up coverage denials. Any unpaid amount by the insurance company becomes my responsibility to pay Sleep & Lungs.

In the event no insurance is available, payment for services rendered on my behalf and/or my beneficiaries becomes my responsibility.

I also acknowledge:

- Applicable co-pays are due at time of service,
- Checks returned to our office for insufficient funds will be assessed a $25 fee,
- Charges for medical records will be due when picked up,
- Unpaid balances after 30 days are considered delinquent, and
- Any applicable collection fees such as delinquent interest, collection agency fees, and legal/court fees incurred by Sleep & Lungs in attempting to collect unpaid balances will be my responsibility.

Forms of payment accepted are: cash, checks, money orders, debit and credit cards

Responsibility Party Name: _____

Responsible Party SSN: _____

Patient Names: _____ _____

_____ _____

_____ _____

Phone: _____ Email: _____

Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____