Sleep Wellness Clinics of America, PLLC
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AUTHORIZATION TO RELEASE BILLING INFORMATION:

Patient's name:_____D.O.B:_____

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals and entities authorized by me or their contracted entities. [If the patient is a minor, the parent or legal guardian must sign].
Please note that the use of all daily authorized and released records are not under Sleep Wellness Clinics control.

- AUTHORIZATION FOR PATIENT PICTURE: I hereby authorize Sleep Wellness Clinics to take a picture for my electronic medical records if I do not produce a current Photo ID.

ASSIGNMENT OF BENEFITS TO SLEEP WELNESS CLINCS:

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by **Sleep Wellness Clinics** and the medical professionals caring for me during my treatment in this office to be paid directly to **Sleep Wellness Clinics**, or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance including collection agency fees for their services if needed.

Typical charges include initial consultation, home sleep study and follow up visit charges. If an in-lab study is needed interpretation fees will also be added.

This assignment will remain in effect until revoked in writing by me.

_____

Signature of Patient/Patient's Representative Date :

Printed Patient Name :_____