

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_,understand that I have an insurance which may have special provision regarding medical coverage, and Lung Associates will supply all documents they have for an approval and reimbursement of service needed provide my care, **ONCE.**

It will be **MY DUTY** to seek for the authorization with my insurance company if these services are denied within 2 weeks of submission of the documents.

I agree that if these services are denied I will pay out of pocket, If I wish the procedure done or I will work with my insurance company for approval after Lung Associates apply only **ONCE**. I will not hold accountable Lung Associates PA /Sleep Disorder Clinic PA if these studies are not done in a timely fashion to preserve my health care.

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Patient Signature and date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature and date