Weill Cornell Medicine Center for Sleep Medicine
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# Weill Cornell Medicine Center for Sleep Medicine Financial Policy

Welcome to the Weill Cornell Medicine Center for Sleep Medicine. The following is a statement of our Insurance and Financial policies.

**Weill Cornell Medicine Center for Sleep Medicine Responsibilities:**

The Weill Cornell Medicine Center for Sleep Medicine will bill your insurance company for professional services and/or testing. The utmost care will be given to your claim to ensure maximum usage of your benefits.

**Self-pay patients please be advised that payment is due at the time of service.**

The Weill Cornell Medicine Center for Sleep Medicine does not take assignment, and you will be responsible for the balance that your insurance has not covered. Our clinician's participate in many of the major managed care plans and every effort will be made to schedule you with a provider participating in your plan.

**Patient Responsibilities:**

Please be advised that it is your responsibility to obtain insurance referrals. If you do not have a referral you may have to reschedule your appointment.

The Weill Cornell Medicine Center for Sleep Medicine is not responsible if your insurance company does not pay for your professional services and/or testing. You are financially responsible for non-covered services, co-payments, co-insurance payments, and deductibles.

**If you choose to see a provider out of your insurance plan you will be considered a self-pay patient.**

It is your responsibility to make certain that the Weill Cornell Medicine Center for Sleep Medicine has updated insurance information to avoid costly medical bills.

In case you elected to pay out of pocket for a test that your insurance has denied coverage for or authorization is pending, by initializing here, you acknowledge that you will be financially responsible for costs of the service provided by the Weill Cornell Medicine Center for Sleep Medicine. Initials: _____.

**The fees due at the time of service are the following co-payments, co-insurance payments, deductible payments, and self pay fees.**

**I understand and agree with following the above policies.**

**Signature** _____ **Print Name** _____ **Date** _____