



PRACTICE TERMS AND CONDITION OF SERVICES

Sleep Life Med is a private integrative sleep medicine practice that partners with you in your journey towards optimal sleep health and wellness. Understanding the practice terms and conditions of services is vital to this partnership. We invite you to read this form thoroughly and ask Dr. Cacho or her staff and questions you have.

PATIENT VISITS:

CONSENT FOR TREATMENT

I consent to medical treatment at Sleep Life Med. I acknowledge that Dr. Cacho at Sleep Life Med has not provided any guarantees to my condition because of the diagnosis, examination and/or treatment.

INSURANCE HOLDERS

I understand that Sleep Life Med participates in select insurance plans. If Dr. Cacho does not participate in my insurance plan she is considered an out-of-network provider.

I understand that my insurance card must be available at the time of services and I will notify Sleep Life Med of any changes to my insurance plan.

I understand that my insurance coverage is a contract between myself and my insurance company. I am responsible for finding out the coverage my insurance provides and any copayment, coinsurance and deductibles for services recommended by Dr. Cacho.

I understand that Sleep Life Med will bill my insurance for covered services and copayment, coinsurance and deductibles are my responsibility and will be collected at the time of service.

I understand that some insurance plans require my primary care provider to obtain a referral authorization number from the insurance company prior to seeing Dr. Cacho. A referral requirement is the result of your contract with your insurance company, and it is your responsibility to ensure that it has been done.

If your insurance company denies payment because a referral has not been obtained, you will be responsible for the cost of the visit.

NON-INSURANCE HOLDERS

Sleep Life Med will provide you with the fee schedule. Services paid in full on the date of service will receive a 30% discount. If you elect to pay the full amount, 50% of the fee is due on the date of service and the remaining amount will be billed to you and final payment is due within 60 days.

APPOINTMENT POLICY:

I understand that a scheduled appointment is a commitment of time between myself and the physician. At your request we have reserved time for you. We request you make every effort to keep your appointment. We understand that emergencies arise, and we reserve the right to charge no show or late cancellation fees.

Missed appointments or appointments canceled without required notice will be charged as follows:

-\$50 fee for physician appointments cancelled without advanced notice of 2 business days.

-\$75 fee for home sleep study appointments cancelled without advance notice of 2 business days.

Dr. Cacho desires for all patients to have the opportunity to be seen for his or her entire scheduled visit time. If you arrive late to your appointment, we will do our best to work you back into the schedule, however, you may be asked to reschedule.

TELEHEALTH CONSULTATIONS:

I understand that telehealth consultations are available at Sleep Life Med. There are some potential risks with the use of telehealth which include but may not be limited to:

- The inability to perform some aspects of the physical examination or evaluation.
- Insufficient information to allow appropriate medical decision making by the physician and consultant.
- Delays in medical evaluation or treatment due to technical deficiencies or failures of the equipment.
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment errors.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment. I understand that I may at any time choose to see Dr. Cacho in person if it is in accordance with federal and state rules regarding health and safety. I understand that my doctor assumes that I am alone during our conversation and will not know if there are other people in the room or within hearing distance unless I disclose this information. As such confidentiality may be breached if Dr. Cacho discusses topics of private nature that are relevant to my care.

If interruptions arise due to technical difficulties my doctor or I can discontinue the visit at any time if we desire. I understand that if my doctor feels that a direct physical examination or other testing is necessary she will ask me to come in for a face-to-face visit to complete this examination or other testing.

FINANCIAL POLICIES

FINANCIAL RESPONSIBILITIES:

I understand that I am financially responsible for all charges whether covered by my insurance carrier. These include deductible, co-payment, cost-share, and/or non-covered benefits. My patient financial responsibilities of copays, coinsurance and deductibles are due at the time of service.

I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest allowed by law, all without relief from valuation and appraisal laws.

Insurance companies provide patients with an explanation of benefits (EOB) showing my total patient responsibility. Any dispute I have with the amount owed is between myself and my insurance company.

A late fee of \$5 per month will be applied to outstanding bills over 60 days. Outstanding balancing must be paid in full prior to scheduling and/or obtaining the subsequent office or procedure visit.

Hawaii residents are financially responsible for the general excise tax.

For your convenience encrypted credit card storage is available through a 3rd party system. Only the last 4 credit card digits will be available to the staff at Sleep Life Med. Please complete the credit card authorization form if this option interests you.

COLLECTION POLICY:

I understand that I am responsible for paying for outstanding balances for services obtained at Sleep Life Med. We understand that healthcare is often a large expense and can offer payment arrangements, as necessary.

If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 120 days of repeated attempts, the account will be turned over to our collection agency and you will be discharged from the practice.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS:

I authorize release of any medical care information requested by my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of medical care.

I authorize payment to be made directly to Sleep Life Med by my insurance company, and I accept financial responsibility for all services not covered by my insurance.

I authorize the use of my signature below on all my insurance submissions whether manual or electronic.

PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have received my Rights and Responsibilities as a patient and a written copy will be provided to me at any time upon my request. I understand Sleep Life Med has a link to the Patient Rights and Responsibilities on the practice website located at: <https://sleeplifemed.com>

PATIENT COMMUNICATION

I understand that I may be asked to schedule an appointment if issues or questions arise between scheduled appointment times. The best way to discuss my care is in a scheduled visit time to allow for examination and review of information, as necessary.

I understand that information will not be provided to a family member or friend unless a signed permitted communication form is completed and is on file.

I understand that there are privacy concerns with my standard personal email. Sleep Life Med provides HIPPA secured messaging for text and email via the Spruce Health app or via email with Patient Passport Portal from Elation Health at no additional cost to me. If I prefer to use my standard personal email for communication I am aware that I am vulnerable to security breaches.

Communication for medical questions or concerns via telephone or email will be subject to the following billing codes as applicable. Please check with your insurance company if they cover these services and what charges fall under your responsibility.

	5-10 minutes	11-20 minutes	21-31 minutes
Telephone	99441	99442	99443
Email	99421	99422	99423

CONTROLLED MEDICATIONS/MARIJUANA POLICY:

Dr. Cacho does not prescribe opiates, benzodiazepines, or medical marijuana for the treatment of insomnia. She provides an integrative approach to insomnia and provides non-pharmacotherapies for this condition. She will not take over prescribing these medications from another physician.

There are sleep disorders where standard of care includes stimulant medications. Complete medical records must be available for continuation of these medications if you are transferring care. If no records are available, sleep testing may be ordered prior to the continuation of these medications.

MINORS OR INCAPACITATED PERSONS:

- This patient is a minor of _____ months/years of age.
- Incapacitated and unable to sign for the following reason(s):

ATTORNEYS:

I understand that in the event Dr. Cacho is required to hire an attorney or is required to appear in court, the current hourly rate of the attorney's fee schedule, billed by the quarter hour or fraction thereof, will be charged to me.

DISMISSAL POLICY:

I understand that there are situations in which I may be dismissed from Sleep Life Med. They include but are not limited to the following:

- Failure to keep scheduled appointments
- Noncompliant or abusive behavior
- Failing to pay outstanding balances
- Posing a threat to the physician, staff, other patients, or neighboring businesses
- Any deceptive or criminal behavior

UPDATES

Sleep Life Med will update these terms and conditions of services from time to time. You may review the latest policies upon request.

ACKNOWLEDGEMENT OF PRACTICE TERMS AND CONDITION OF SERVICES and PRIVACY POLICY:

I certify that I have read the practice terms and condition of services policies of Sleep Life Med, and I agree to abide by these policies.

_____ (initial) I have read a copy of Sleep Life Med's Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Sleep Life Med has a link to the Notice of Privacy Practices on the practice website located at: <https://sleeplifemed.com>

PATIENT OR REPRESENTATIVE SIGNATURE **DATE:** _____ **TIME:** _____

PRINT NAME
RELATIONSHIP TO PATIENT (please check): **Self** **Other:** _____

Note: The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.

Effective Date: 1/12/2021
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