sleeplifemed
5300 Katella Ave, Los Alamitos, CA 90720
Phone: 657-553-3799 I Fax: 808-460-3840
hello@sleeplifemed.com

PRACTICE TERMS AND CONDITIONS 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 THE PHYSICIAN OR STAFF AND QUESTIONS YOU HAVE.

PATIENT VISITS

CONSENT FOR TREATMENT

- I consent to medical treatment at Sleep Life Med. I acknowledge that physician 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 physician 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 physician.
- 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 physician 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. Payment is due at the time of the visit.

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 canceled without advanced notice of 24 hours.
- $100 fee for home sleep study appointments canceled without advance notice of 24 hours.

The physician 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.

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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 physician 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 the physician 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 physician 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 with cash, check or credit card.
- 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 appraisement 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.

CREDIT CARD POLICY:

For your convenience encrypted credit card storage is available through a 3rd party system. 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.
- 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 a collection agency and you will be discharged from the practice.

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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.

CONTROLLED MEDICATIONS/MARIJUANA POLICY

The physician does not prescribe opiates, benzodiazepines, or medical marijuana for the treatment of insomnia and provides an integrative approach to insomnia and provides non-pharmacotherapies for this condition. The physician 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.

INCAPACITATED PERSONS

Incapacitated and unable to sign for the following reason(s):

_____

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ATTORNEYS

If the physician needs to hire an attorney or appear in court because of any legal matter related to my care, I agree to cover the related costs. This includes the attorney's fees at their current hourly rate (billed in quarter-hour increments), as well as any court or administrative expenses that may arise.

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.

PHOTO IDENTIFICATION AND SIGNATURE

The patient (or guarantor) must sign this form and provide a valid photo ID before the appointment. This helps us verify your identity, protect your personal information, and prevent insurance or billing fraud.

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:

Effective Date: 1/12/2021
Revised on: 10/01/2025