Louisiana Sleep Foundation, LLC

Authorization Form

Release of Information

Louisiana Sleep Foundation, LLC is hereby authorized to release information relative to my illness (including any resulting effect it has had on my family life and financial situation) to my insurance company and any physicians, medical facilities, or community agencies which may potentially offer me assistance.

Obtaining Information

I hereby request and authorize you to furnish Louisiana Sleep Foundation, LLC any and all information you have concerning me in connection with any illness, condition, or injury, including medical history, consultations, prescriptions, treatment, x-rays, and/or copies of any and all hospital or medical records which you have pertaining to me. A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization is valid until revoked in writing by me.

Insurance

I hereby authorize Louisiana Sleep Foundation, LLC to furnish information to insurance carriers and doctor's offices concerning my illness and treatments. This signature also authorizes you to give me reasonable care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collections on this account.

Financial Responsibility

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Louisiana Sleep Foundation, LLC for any services furnished to me by these providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for charges at all times.

HIPPA Policy

I understand any and all of my health information will be kept confidential at Louisiana Sleep Foundation, LLC. I have read and carefully reviewed the HIPPA Policy at Louisiana Sleep Foundation, LLC and agree with the terms.

Disclosure of Financial Interest

This disclosure is made by: J. Kyle Schwab, M.D., located at 4660 Bluebonnet Blvd., Baton Rouge, LA 70809, telephone number 225.767.8550; and William Hunter Hardin, N.P. located at 4660 Bluebonnet Blvd., Baton Rouge, LA 70809, telephone number 225.767.8550; (hereinafter collectively referred to as ("Healthcare Providers")

Healthcare Providers are the sole, equal shareholders within Louisiana Sleep Foundation, LLC. ("LSF"), which you (or the patient for whom you are the legal representative) are being referred to by a sleep study or related procedure. LSF is located at 4660 Bluebonnet Blvd, Baton Rouge, LA 70809.

You are not required to utilize LSF for these services. These services are available elsewhere in the community. This office will provide an alternative referral upon your request.

Patient Acknowledgement

I, the named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

Telemedicine

Louisiana Sleep Foundation, LLC is hereby authorized to contact me to conduct my visit via Telemedicine. I understand there will be a charge associated with this form of visit and I am financially responsible. I choose to decline Telemedicine._____
Patient Initials

_____	_____	_____	_____
Print Full Name	Signature	Date	Time

If you are not the patient, please state your relationship to the patient: _____

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