NAME: _____ DOB:_____ TODAY'S DATE _____

Authorization to Release Information

I authorize Pulmonary & Sleep Specialists, PC to release any medical information necessary to process TPO (treatment and payment options) and certify that the demographic information I provided is correct. With this consent, PSS may mail to my home or other alternate location, any items that assist the practice in carrying out TPO, such as statements marked personal & confidential.

X _____
Signed (Patient or Responsible Party)

Authorization to Pay Benefits

I authorize and assign direct payment to Pulmonary & Sleep Specialists, PC of surgical and medical benefits. I understand that I am responsible for charges not covered by this assignment. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

X _____
Signed (Patient or Responsible Party)

PRIVACY PRACTICES

Right to a Paper Copy of This Notice.

A copy of Pulmonary & Sleep Specialists, PC "Notice of Privacy Practices" was made available to you on our website: www.pssatl.com and a printed copy made available in our waiting area. A printed copy will be provided to you personally upon request.

I have reviewed and read the Notice of Privacy Practices of Pulmonary & Sleep Specialists, PC. I understand that if any changes are made to this Notice of Privacy Practices a revised copy of the Notice will be posted in the offices of Pulmonary & Sleep Specialists, PC. I also understand that if I wish to receive a copy of this Notice of Privacy Practices or if have any questions with regard to this Notice of Privacy Practices, I may contact Tina Davis, Compliance Officer for Pulmonary & Sleep Specialists, PC, 2665 North Decatur Rd., Ste 230, Decatur, GA 30033, 404-499-0533.

By signing this form, I am consenting to PULMONARY & SLEEP SPECIALISTS, PC's use and disclosure of my Personal Health Information to carry out Treatment and Payment Options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. I consent to being contacted through any method deemed necessary as long as this contact does not disclose my PHI. If I do not sign this consent, or later revoke it, PULMONARY & SLEEP SPECIALISTS, PC may decline to provide treatment to me.

Signature of Patient or Legal Guardian: **X**_____

Financial Policy

I understand that co-pays are due at time of service and that I am responsible for the cost of any service provided that is not covered under the terms of my insurance. If payment for services is not covered under the terms of my insurance policy I understand that I am responsible to pay 100% of these costs AT THE TIME OF SERVICE unless a payment arrangement has been made with Pulmonary & Sleep Specialists, PC.

I further acknowledge that it has been explained to me that unless I provide 48 hours notice of cancellation for my appointments with my physician, that in order to reschedule the missed appointment I must make a deposit of $50. If I keep my rescheduled appointment, that amount will be applied against any co-pays or balances for services that I might incur.

I acknowledge that it has been explained to me that unless I provide 48 hours notice of cancellation for my appointment for any type of sleep study, that in order to reschedule the sleep study I will be required to make a deposit of $150. If I keep my rescheduled appointment, that amount will be applied against any co-0pays or balances for services that I might incur.

Signature **X**_____ PRINT NAME:_____