Sleep & Pulmonary Care Center, P.C.

CONSENT FOR TREATMENT AND CONDITIONS OF TREATMENT

I. CONSENT FOR TREATMENT:

This is my authorization and consent for care and treatment including routine diagnostic procedures, radiation treatments and chemotherapy treatments by Sleep & Pulmonary Care Center, P.C. and its agents. It is understood that while a patient being treated as an Inpatient or Outpatient, I will be under the general care of my physician and I do hereby authorize and consent to all care and treatment administered by Sleep & Pulmonary Care Center, P.C. and its authorized representatives and I consent to any further examination, care and treatment which may be deemed advisable and/or appropriate by my physician or by authorized representatives of Sleep & Pulmonary Care Center, P.C.. I acknowledge that no guarantees have been made to rue as to the effect of such examination or treatment on my condition.

2. PERSONAL VALUABLES:

I acknowledge that Sleep & Pulmonary Care Center, P.C. shall not be liable for the loss or damage to any personal property.

3. PERMISSION FOR DISCLOSURE OF INFORMATION:

This authorizes Sleep & Pulmonary Care Center, P.C. and its representatives and employees to release all information, including, but not limited to, copies of medical and other records relative to this treatment, testing and diagnosis to all insurers, third party payors, other health care institutions or entities involved in patient transport or continuing patient care, CHAMPUS, physicians or agencies performing review functions authorized by contract, law or regulation.

4. FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:

The undersigned agree(s), whether signing as agent or as patient that in consideration of services to be rendered to patient, the undersigned is obligated to pay for same in accordance with the regular rates and terms Sleep & Pulmonary Care Center, P.C.; and that should the account be referred by Sleep & Pulmonary Care Center, P.C. to an attorney for collection, the undersigned shall pay all reasonable attorneys fees, interest and all costs of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of Alabama or any other state as to his personal property.

In the event the undersigned and/or patient is entitled to hospital Inpatient, Outpatient, or Emergency Room benefits of any type, whatsoever, arising out of any insurance or any other party liable to the patient, then the undersigned assigns such benefits to Sleep & Pulmonary Care Center, P.C. and Mamoun Najjar, M.D.. The undersigned hereby authorizes and directs that **all insurance benefits assigned shall be paid directly to** Sleep & Pulmonary Care Center, P.C. and/or Mamoun Najjar, M.D. for the respective services rendered. The undersigned and/or patient agrees and understands that acceptance of insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient. **The undersigned and/or patient is responsible for the compliance with any pre-certification and/or other requirements of any insurance company or third party payors.** The undersigned and/or patient is responsible for any difference not paid by insurance charge structure used by the insurance company or third party payors versus that of the medical provider.

5. STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER

The undersigned and/or patient certifies that the Information given by his/her in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. The undersigned and/or patient requests that payment of authorized benefits be made to Sleep & Pulmonary Care Center, P.C. and/or Mamoun Najjar, M.D. for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to the Health Care Financing Administration, the State of Alabama, their intermediaries, carriers or agents any information needed to determine these benefits or benefits for related services. It is understood that the undersigned and/or patient is responsible to Sleep & Pulmonary Care Center, P.C. and Mamoun Najjar, M.D. for any health insurance deductibles and coinsurance.

The undersigned and/or patient certifies that he/she has read the foregoing and agrees and accepts same.

_____	_____	_____
Policyholder	Patient/Agent or Representative, Relationship	Date
_____	_____	_____
Policyholder	Patient's Agent or Representative	Relationship to Patient