



FEES AND PAYMENT POLICY

The following outlines our policy regarding fees and payment and third party claim reimbursement. We are committed to providing excellent service at a reasonable cost and will attempt to make your experience as convenient as possible.

In general, insurance companies do not reimburse expenses for snoring treatment. All fees for services provided are due in full **at the time of service**. The Snoring Center **does not** contract with carriers of any sort or participate in any insurance plans and is considered an "out of network" provider.

The fee for an initial consultation is \$50.00. The fee for comprehensive snoring treatment is \$3900.00. If you undergo treatment, as a courtesy we will submit a claim to your insurance company on your behalf. If your carrier pays a benefit to The Snoring Center, the amount paid will be refunded to you in full. Please allow **thirty (30) days** from the **issue date of the insurance check** (not internet notification) for us to receive and process your payment and to mail your check. Please note that the insurance filing is not a substitute for payment. We do not provide ongoing claims tracking (e.g. follow-up, appeals, etc.). **You will be responsible for the status of your claim and for appealing any denial if you choose to do so.**

If the patient is a Medicare Part B Beneficiary, he/she must complete the attached Medicare Addendum. The Snoring Center and its physicians have opted out of Medicare. The patient understands and agrees not to submit a claim and that Medicare payment will not be made for any items or services furnished by The Snoring Center.

PLEASE SELECT FROM THE FOLLOWING OPTION TO DEFINE HOW YOU WOULD LIKE THE SNORING CENTER TO ASSIST YOU REGARDING INSURANCE FILINGS FOR TREATMENTS:

Option One:

As a courtesy, The Snoring Center will file a reimbursement claim for your treatment on your behalf.

OR

Option Two:

We will provide the documentation necessary for you to file your own claim.

Patient Signature: _____

Date: ____ / ____ / ____

Witness Signature: _____

Date: ____ / ____ / ____



MEDICARE ADDENDUM

The Snoring Center and its physicians have opted out of Medicare and do not participate with Medicare in any way.

This agreement is between the Snoring Center, Dr. Craig Schwimmer (and any other physicians of The Snoring Center) and patient:

_____ (Patient), who resides at _____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective 11/17/2008 for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to patient:

In exchange for the services, the patient agrees to make payments to The Snoring Center pursuant to the fee schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right as a Medicare beneficiary to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understand that Medicare payment will not be made for any items or services furnished by Physician that would otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.

Patient Name

Physician Signature / Date

Physician Name

Physician Signature / Date