Patient Financial Responsibility Agreement

Date: ___________________________

Patient Name: ___________________________

Patient ID: ___________________________

Dear [Patient's Name],

We appreciate your decision to undergo a sleep study at our facility. This letter outlines the financial responsibilities associated with your upcoming sleep study.

Financial Responsibility Overview

- The cost of the sleep study is estimated to be $____________.
- Your insurance may cover part of this cost; however, you are responsible for any copayments, deductibles, or non-covered charges.
- Please verify the coverage details with your insurance provider prior to the study.

By signing below, you acknowledge and agree to your financial responsibility for the services rendered.

Signature: ____________________________________

Date: ______________________________________

Thank you for choosing us for your sleep health care needs.

Sincerely,

[Your Healthcare Facility Name]

[Contact Information]