Hackensack Sleep & Pulmonary Center
170 Prospect Avenue, Suite 20, Hackensack, NJ 07601
Dr. Fariborz Ashtyani and Dr. Deborah (Hutter) Goss
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HACKENSACK SLEEP & PULMONARY CENTER POLICIES

Welcome to Hackensack Sleep and Pulmonary Center. The office of Dr. Fariborz Ashtyani and Dr. Deborah Goss (Hutter). In addition to our physicians, our medical staff is also here to assist you. Please take a few minutes to read the following information related to our office and payment policies.

Authorization to Release Information to Family Members and/or Friends

1. To provide timely service to all patients, a notice of appointment cancellation, at least 24hrs prior to your appointment date\time, is required. Failure to do so will result in a $25 same day/no show fee.
2. Constant reschedules and/or no show appointments adversely affect the function of the office and care of other patients and may result in your discharge from our practice.
3. Copayments are due at time of service. No exceptions. We accept Cash, Checks and Credit cards payments **(Minimum of $20)**
4. **Please be advised that per restrict insurance policies, you may be responsible for any deductible or coinsurance you may have.** Please contact your health insurance if you have any questions regarding your health plan's policy and/or coverage.
5. If payment for services provided by us is sent directly to you by your health insurance, you **MUST** forward the check within IO days along with the explanation of benefits. **NOTE**: you must sign the back and write endorsed to **Hackensack Sleep and Pulmonary Center.** Failure to do so, within the times specified, will result in your responsibility for the **ENTIRE** amount due to our office.
6. In case of any delinquent account resulting in the use of a collection or legal agency, you will incur ALL additional fees and penalties.
7. **Please be advised that in order to protect your privacy, except in life threating situations, NO results will be given over the phone. An appointment must be scheduled for all test results.**

I *(print name)*_____ acknowledge that I have read and understand the above office/payment policies. Should I fail to adhere to any may result in possible discharge from the practice.

Patient Signature **DOB** **Date**