Womenzzz Sleep Health, P.L.L.C.

Patient Financial Responsibility

Dr. L'Heureux's office accepts cash, personal checks, Visa, MasterCard, and Discover as forms of payment.

Returned checks: A $25.00 fee will be charged for any returned personal checks, as well as any additional fees charged to us by our financial institution.

Insurance Co-Payments are paid in full by the patient at the time of service.

If we are not contracted with your insurance plan, or you do not have insurance, payment of the fee for your office visit/home sleep study/actigraphy is paid in full by the patient at the time of service. We will provide you with a coding statement which you may send to your insurance for credit towards your "out of network" deductible if applicable.

Actigraphy: Some insurance plans may not pay for actigraphy although it is recognized by The American Academy of Sleep Medicine as a valid diagnostic procedure to assess a patient for certain circadian rhythm disorders. It is the patient's responsibility to pay the fee for an actigraphy if their insurance denies it.

Referrals: It is the patient's responsibility to know their insurance benefits and to obtain a referral from their primary care physician to see Dr. L'Heureux prior to their visit if needed.

Collection Policy: If your account is placed with a collection agency you will automatically be discharged from the practice. No further appointments will be scheduled and any pending will be cancelled.

No Show Appointments/Cancellations: If you fail to show for an appointment without prior 24 hour notice you will be assessed a $25.00 fee which must be paid prior to your next office visit. A second no show appointment will be assessed a $50.00 fee. You will be discharged from the practice if you fail to show up for three appointments without prior notification.

It is important that patients are knowledgeable and informed with regards to their insurance coverage. It is the patient's responsibility to provide us with updated cards after changes in their plan's coverage or carrier have occurred. The patient will be responsible for paying any unpaid claims, or denials occurring secondary to incorrect information which you have submitted to us.

Signature of Patient/Guarantor Printed Name of Patient/Guarantor Date