



# WESTMORELAND SLEEP MEDICINE

**Bharat Jain, M.D.**

BOARD CERTIFIED IN SLEEP DISORDERS MEDICINE AND PULMONARY DISEASES

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I understand and acknowledge that I am personally responsible to pay **Westmoreland Sleep Medicine** in full for services that my health insurer will not cover or will deny due to non-payment of premiums. I also know that I must pay for any **deductibles** or **copayments** as set forth by my plan.

\_\_\_\_\_  
Print Name Of Patient

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PLEASE NOTIFY OUR OFFICE  
IMMEDIATELY  
WITH ANY INSURANCE CHANGES.**