Home Sleep Study Form

SleepCare

Patient Information:

Patient Name_____ Date _____ DOB _____

Address_____ City _____ State_____ Zip _____

Home Phone_____ Cell Phone _____ Email _____

Primary Care Physician/Practice Name_____ City_____ State_____

Please include a copy of your **insurance card** along with this form

Home Sleep Study Costs

The complete home sleep study consists of the following:
-Equipment sent to your home - priority mail
-Self-administered sleep study
-Return package in prepaid priority shipping
-Review of sleep study by a certified sleep specialist
-Coordination of testing and results with your physician
-Provide paperwork for patient to submit to insurance

To Schedule Your Home Study Call:
1-866-320-8989

Total Cost: $350

Payment Information: Request insurance paperwork? Yes ☐ No ☐

Credit Card Type: ☐ Visa ☐ Mastercard ☐ Discover

Credit Card Number _____ Exp _____ Security Code _____

Name on Card_____ Billing Address_____

City _____ State _____ Zip _____

I. Consent and Release
I give my permission to SleepCare, Inc. staff to complete the home sleep test. I hereby expressly waive any and all claims, which I might, at any time, have against Sleep Care, Inc. its employees, relating to this procedure. I understand the risks associated with Sleep Apnea and do not hold SleepCare, Inc. responsible if I decide to refuse treatment.

II. Financial Responsibility and Assignment of Benefits
I am personally responsible for the payment of all charges incurred through SleepCare, Inc. I understand SleepCare, Inc will only assist me in billing my insurance. I understand that equipment damaged due to patient negligence is subject to repair fees of up to $1000.

III. Late Return Policy
I understand delays in the return of equipment are subject to a late fee of $25 per day.

IV. Authorization for Release of Information
I authorize SleepCare, Inc. to release medical information to any physician treating me related to this test or for related follow up within 90 days. I also authorize release of this information to the insurer or its agents processing the claim for payment. Further, I authorize my referring and interpreting physicians to release history and physical, letters of related consultation, previous sleep study reports, follow up consultations, and DME information to SleepCare, Inc. I give my permission to SleepCare, Inc. to use my information to track medical outcomes and compare my results to the results of other patients so that we can continue to refine our best practices. Information is anonymous and used only for statistical analysis.

V. Privacy Notice
I received a copy of SleepCare, Inc's "Notice of Privacy Practices" for Protected Health Information.

Patient Signature_____ Date_____

Additional Questions can be answered by: SleepCare, Inc. phone 866-320-8989.

Please return form and insurance card copy to SleepCare, Inc. at P.O. Box 418, Worthington, OH 43085 or fax to 1-866-291-8990.