

## **HOME SLEEP TEST CONSENT AND RELEASE FORM**

We have received an order from your doctor for a home sleep test (**HST**). We understand that your doctor has explained the HST to you, including its risks and benefits. We are the HST provider you have chosen. Under your doctor's order, we are providing you with the HST device. It is very important to us that you understand and consent to your financial responsibility and duty to return the HST device. It is also important that you understand your privacy rights. Please sign this Consent Form only after you fully understand your rights and responsibilities, and all of your questions have been answered.

### **YOUR RESPONSIBILITIES**

**HST.** If you have any problems, you must call us immediately at **864-315-0928**. We are always here to answer your questions.

**Use of the HST Device.** You are the only person authorized to use this HST device and take the home sleep test.

**Financial Responsibility.** You are responsible for any allowed amounts your insurance company does not cover, such as deductibles, co-insurance, and denied claims. You authorize us to obtain any information relating to your care from other hospitals, physicians, and providers. You agree to provide Medicare, Medicaid, and other third-party payers with all documents and information we need to obtain payment. You also ask Medicare, Medicaid, and other third-party payers to pay benefits on your behalf directly to us. If you do not have insurance, you must pay us in full before we loan you the HST device.

**Device Return.** We are loaning you the HST device. You must return it to us within 3-days from the date of receipt. If you do not return the HST device to us within the specified timeframe, we will bill you for its cost, up to \$3,995.00.

### **YOUR RIGHTS**

**Privacy Practices.** We are giving you a copy of our Notice of Privacy Practices (**NPP**), which explains how we may use and disclose your health information.

**ACKNOWLEDGEMENT:** By signing below you acknowledge that: (1) You are under the supervision of your physician; (2) Your physician has prescribed HST and you have talked about this with her/him; (3) You will not permit any other person to use the HST device or take the home sleep test; (4) We do not diagnose, write prescriptions, or act as your physician; (5) You have been given our NPP, and (6) You have read and understand the terms of this Consent Form.

**You do not have to sign this Consent Form. If you do not sign, we will not loan you the HST Device.**

Printed Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Printed Name of Legal Representative (If applicable)

\_\_\_\_\_  
Witness

Best telephone number to reach me: \_\_\_\_\_

I have received face-to-face instruction on how to use this device. Please Initial: \_\_\_\_\_

Device Number: \_\_\_\_\_

## Credit Card Authorization Form

Please complete all fields.

This authorization will remain in effect until the home sleep testing device is returned

Credit Card Information			
Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> VISA	<input type="checkbox"/> Discover <input type="checkbox"/> AMEX
	<input type="checkbox"/> Other _____		
Cardholder Name (as shown on card): _____			
Card Number: _____			
Three Digit Code on Back: _____			
Expiration Date (mm/yy): _____			
Cardholder ZIP Code (from credit card billing address): _____			

I, \_\_\_\_\_, authorize \_\_\_\_\_ to charge my credit card above for agreed upon purchases if the home sleep testing device is not returned within 3 days. I understand that my information will be saved to file for future transactions on my account.

\_\_\_\_\_  
Customer Signature

\_\_\_\_\_  
Date