SOMNIQUE HEALTH

Patient Name:_____
(*Print name and sign below)*

DISCLOSURE AND AUTHORIZATION

Patient Consent

I am requesting that Somnique Health and the doctors who practice there will test me for possible sleep disorders. I understand that as a patient, I am required to authorize Somnique Health for such services. I am hereby authorizing such tests. I understand that photos, digital video, and other images may be recorded to document my care, and I consent to this. I understand that Somnique Health will retain the ownership rights to the photos, digital video, and other images but that I will be allowed to view them and obtain copies upon my request. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for a time period that is required by law. I have consulted my physician and I understand the tests that I will undergo. By signing this consent, I authorize the Somnique Health staff to perform the tests that are ordered by the physician.

Receipt of Notice of Privacy Practices and Disclosure, Patient Rights and Responsibility, and Provider Performance Standards

I have reviewed and understand the Privacy Practices, Patient Rights and Responsibility, and Provider Performance Standards. I understand my rights as they are contained in these documents. I authorize the use and disclosure of my health information for the purposes of treatment, determination of benefits, payment, and care as described in the Privacy Practices. This includes any doctors and their staff who provide services for Somnique Health, durable medical equipment company and their staff which will provide me with medical equipment. I authorize Somnique Health to leave voicemails on the phone numbers I have provided to them, and with whoever may answer at those phone numbers. This may include messages that are left at my business.

Patient Assignment of Benefit Agreement

I understand that the explanation of benefit from my insurance carrier is not a bill from Somnique Health. I understand that no charges are due from me until I receive a statement from Somnique Health. I understand that if I have billing questions, I can call Somnique Health to provide me with these answers and that they may seek assistance from eCW (their electronic medical records and billing company).

I understand that ultimately I bear the responsibility for the payment of all fees associated with the procedures provided by Somnique Health. I am responsible for all charges not covered by my insurance carrier and if I receive any payments from my insurance carrier directly, I will immediately forward such payment to Somnique Health for the services they provided. Services provided may include tele-medicine visits.

I authorize direct remittance of payment of all insurance or Medicare benefits to Somnique Health for all covered services. I understand and agree that this assignment of benefits will have continuing effect for so long as I am being cared for by Somnique Health. I authorize my insurance company to mail all payments directly to Somnique Health.

Commercial Drivers

I understand if I am diagnosed with a sleep disorder, the Department of Motor Vehicles may be contacted if I do not follow my doctor's instructions and recommendations, or if I am found to be non-compliant with my treatment.

Past Due Accounts

I understand that a fee may be charged on all accounts which are 90 days or more past due at a rate of 1% per month. I understand that the 1% may be added to the account and hereby agree to pay such charges if levied. I also understand that if my account is placed with a collection agency, additional fees with ensue including court costs and those fees will be added to my account balance.

Check Acceptance Policy

Checks that are returned to Somnique Health unpaid from your account will be assessed an additional **$25 NSF fee**. Returned balance plus additional fee will be required to paid off in the form of cash or credit card. We accept Visa, Mastercard, American Express and Discover.

Cancellation Policy

I understand that I must provide at least a 24 hour notice to any appointments I am unable to keep. If I do not provide at least a 24 hour notice prior to a cancellation or if I do not show up for a scheduled appointment I understand that I will be charged a cancellation fee of $50.00 for clinic visits and $200.00 for sleep studies.

I have read and understand all of the above, and my initials and signature represent acceptance and acknowledgement for all of the above. I authorize a copy of this form to be used in place of the original.

_____ _____

SIGNATURE DATE