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CMD
Sleep Disorders Center

# HOME SLEEP TEST CONSENT AND EQUIPMENT ACKNOWLEDGMENT

## Patient Information

Last Name: _____ First Name: _____ DOB: ____/____/_____

Preferred Contact Number: _____Home – Cell – Work (Circle one) Sex: M F

Credit Card Type: Visa – MC – American Express – Discover –Others_____

Notes: Your credit card will not be charged unless you fail to return the equipment to our practice. Note: There will be a 4% processing fee for all credit card transitions. (*In the event that the machine is not returned, you will be charged $200 per day for late fee*). (*A copy of the card will be asked to be put on file upon pick up of the equipment*).

## Consent

I, _____ agree to have a Home Sleep Test (HST) performed on me as specified by my medical provider's order. The procedure involves the attachment of a belt and monitoring device that I will be responsible for using. I understand that the proper administration of my HST will be explained to me and that I will receive adequate written and visual education materials to properly administer the test. We ask that you acknowledge your receipt of this equipment, and that you agree to return the equipment after completion of the study. (*I acknowledge that failure to return the equipment provided to me will result in my credit card being charged for the late fee.*)

## Acknowledgement of Receipt of Testing Equipment

I acknowledge receipt of Home Sleep Testing equipment and agree to use and start the study on the date equipment is picked up and return the device and its parts as listed below, by the date noted below. Should I fail to return the equipment and all related components in the condition in which they were received, I agree to pay CMD Sleep the fee for replacing devices which have been lost, damaged or not returned, of up to $1000. The kit contains the following:

-Ares Unicorder -Respiratory Belt -USB Charger -User Guide -Travel Case

*(To be completed by the office staff)*
**Equipment pick-up date: _____**
**Expected equipment return date: _____** *Return by 10:00 AM local time*

## Release of Information and Patient Confidentiality

*Comprehensive Medical Diagnostics, LLC (CMD Sleep) will provide a copy of the results of any procedure performed to the ordering physician. The undersigned further acknowledges that CMD Sleep is authorized to provide these results to other physicians and/or durable medical equipment companies as requested to complete prescriptions for equipment (ex: CPAP machine) that may be ordered as a result of the sleep study findings.*

*I certify the information that I have provided is correct. I authorize the release of medical information necessary to process claims to insurance companies or their agencies. I ACKNOWLEDGE THAT IF I FAIL TO RETURN THE EQUIPMENT AS LISTED ABOVE, A LATE FEE MAY BE CHARGED TO MY CREDIT CARD. I permit a copy of this acknowledgement to be used in place of the original.*

Signature: _____ Date: _____

Relationship to patient: _____ Representative Name (printed): _____