Patient Disclosures and Authorizations Signature Form

Instructions: Print Name in Spaces, Sign and Date at bottom of next page**:**

Patient Consent:

I, _____, am requesting Advanced Sleep Centers and the physicians who practice there to test me for possible sleep disorders. I understand that as a patient, I am required to authorize Advanced Sleep Centers for such service and am hereby authorizing such tests. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Advanced Sleep Centers will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. I also acknowledge that I have consulted my physician and understand the nature of the test(s) that I am about to undergo with Advanced Sleep Centers. By signing this document, I consent to the tests that will be performed on me by the staff of Advanced Sleep Centers.

Receipt of Notice of Privacy Practices Written Acknowledgement:

I, _____, have reviewed the Privacy Practices of Advanced Sleep Centers and received a copy at my request.

Commercial Drivers:

If I am diagnosed with a sleeping disorder, I understand the Department of Motor Vehicles may be contacted if I do not follow my doctor's instructions and recommendations or am not compliant with my treatment plan.

MEDICARE AUTHORIZATION STATEMENT

I request that payment of authorized Medicare benefits be made to me or on my behalf to Advanced Sleep Centers for services furnished me by the physicians or the center. I authorize any holder of medical information about me be released to the Health Care Finance Administration and its agents any information needed to determine these benefits or benefits payable for related services.

Patient Assignment of Benefits Agreement

I understand that my medical insurance carrier may send the reimbursement payment for the procedures performed by Advanced Sleep Centers to me directly. By signing this agreement I am assigning all my benefits to Advanced Sleep Centers and authorize my insurance company to mail ALL PAYMENTS directly to Advanced Sleep Centers.

I understand that I ultimately bear the financial responsibility for the payment of all fees associated with the procedures provided by Advanced Sleep Centers and if any payments are received from my insurance carrier directly to me, I will immediately sign and forward such payment to Advanced Sleep Centers for services rendered.

SIGNATURE:

I have read all of the above and my signature represents acceptance and acknowledgement of all the above: Patient Consent, Patient Authorization for Release of Medical Records, Notice of Privacy Practices, Notice to Commercial Drivers, and Authorization for release of medical records to process insurance claims, Medicare Authorization Statement, and the Patient Assignment of Benefits.

SIGNATURE: X_____DATE: _____

_____

print name