Natrona Heights Sleep Center

POLYSOMNOGRAPHY TEST AUTHORIZATION

Patient Name: ____ **Date**: ______________________________

CONSENT TO DIAGNOSTIC PROCEDURE

I do voluntarily seek and consent to medical care under the direction of Dr. _________________________________ and any consultants he/she asks to assist him/her. I hereby authorize consent for a Diagnostic/Therapeutic/MSLT/MWT Polysomnography Test as directed by my referring physician. I am aware that the practice of medicine is not an exact science and that no guarantees have been made as to the results of the test(s) specified above. I understand that in the event of a medical emergency my physician will be contacted and if immediate medical care is needed, EMS will be summoned and I will be taken to the emergency room of the nearest hospital.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize **CENTER POINTE SLEEP ASSOCIATES, LLC** to release any medical information including diagnosis and records of any treatment rendered to me or my child during the period of medical/surgical care which may be necessary for either medical care or in processing for financial benefit. I understand this may be done via U.S. mail, email and/or fax.

AUTHORIZATION OF PAYMENT

I hereby authorize payment of medical benefits directly to **CENTER POINTE SLEEP ASSOCIATES, LLC** for services rendered to me during the period of my medical/surgical care. I understand that I am financially responsible for any balance not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

MEDICARE / MEDIGAP AUTHORIZATION

FOR MEDICARE/MEDIGAP PATIENTS ONLY

I hereby request that payment of Medicare/Medigap benefits be made either to me or on my behalf to **CENTER POINTE SLEEP ASSOCIATES, LLC** for services rendered to me by that physician, clinic or supplier. I authorize any holder of Medicare information about me to be released to the Centers for Medicare Services (CMS) and its agents, information needed to determine the benefits payable for related services. ☐ Check if not applicable ____________

Patient Initials

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE

I understand **CENTER POINTE SLEEP ASSOCIATES, LLC**, the referring physicians and interpreting physicians are a part of an organized healthcare arrangement and these providers may share my health information for treatment, billing and healthcare operations. I have been given the opportunity to review a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand the organized healthcare management arrangement has the right to change this notice at anytime. My signature below constitutes my acknowledgement that I have been provided with an opportunity to receive a copy of the Notice of Private Practices.

By signing below, I acknowledge that I have read and understand all of the above.

____ ________________________

Signature of Patient, Guardian or Parent if a Minor *Date*

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Relationship to patient if signed by a legal representative