



# REM DIAGNOSTICS

## SPECIALISTS IN SLEEP

### Home Sleep Study Consent for Treatment and Financial Responsibility

#### Consent for Medical Procedure

The undersigned consents to undergo the home sleep study procedure as specified by their medical provider's order. The purpose of this procedure is to record various parameters of sleep to diagnose and or aid treatment of sleep abnormalities.

#### Technical Services and Professional Interpretation

REM Diagnostics, Inc. will bill for the global component of the sleep study. A physician's interpretation is also required. You are financially responsible for any portion of this bill that is not covered by insurance and as otherwise described under your insurance Assignment of Benefits.

#### Assignment of Benefits and Financial Responsibility

REM Diagnostics, Inc. will bill services to any third-party payor for which the patient has provided documentation, generally in the form of a medical insurance policy card. The undersigned authorizes direct payment of insurance benefits to REM Diagnostics for services rendered. It is understood that the undersigned is financially responsible for all charges not covered by insurance. If your insurance changes prior to your appointment/study, please contact our office immediately, to determine if authorization will be required. Failure to do so may result in denial of your services and would become patients responsibility due in full. To reschedule contact the office within two business days prior to your scheduled sleep study. **There is a fee of \$50.00 for any no-show appointments.**

#### Release of Information and Patient Confidentiality

REM Diagnostics, Inc. will provide a copy of the results of any procedure performed to the ordering physician. The undersigned further acknowledges that REM Diagnostics, Inc. 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.

My signature below, or that of my representative, acknowledges I have received a copy of this Consent for Treatment and Financial Responsibility and REM Diagnostics Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Print

\_\_\_\_\_  
Patient (or Authorized Patient Representative) Signature

\_\_\_\_\_  
Date