Patient Registration Form

U.S. Sleep Diagnostics

Patient Demographics:

Name: _____ Sex: _____ DOB: _____ SS#: _____

Address: _____City: _____State: _____Zip: _____

Home phone: _____Work phone: _____Cellular phone: _____

Insurance Information:

Primary Insurance Name: _____ ID#:_____ GRP#:_____
Secondary Insurance Name: _____ ID#:_____ GRP#:_____

Assignment Of Benefits/Statement Of Test Authenticity

I, the undersigned, hereby authorize payment be made on my behalf to the organization listed at the top of this page for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary. I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company received the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and/or services received.
I, the undersigned, also certify that I am the recipient of the ALICE PDX recorder. If said recorder is not returned, I will be charged the replacement value in the amount of $2,500. I also certify that the test was actually performed on me at the dates specified below.

TEST STARTED: Date: _____TEST ENDED: Date: _____ DEVICE SERIAL#_____

TEST WAS DONE ON: ☐ Room Air ☐ Oxygen ☐ CPAP/BIPAP

PATIENT SIGNATURE: _____ DATE: _____

MEDICAL RELEASE

I, the undersigned, authorize the organization at the top of this page to use and disclose my health information for the purpose of treatment, obtaining payment, or supporting the health care operations of my ordering physician. I also authorize the organization at the top of this page to use facsimile with confidential disclosure of my results to my ordering physician, and the DME provider.

PATIENT SIGNITURE:_____DATE:_____