U.S. Sleep Diagnostics
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"Innovative Solutions for Patients and Medical Professionals"

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Account Enrollment Form

Date: / / Representative: Phone:

Account Name: email:

Office Address: State: ZIP:

Office Phone: Office FAX:

Prescribing Physician NP, PA: Specialty:

NPI# Notification Ph #: *- if different from above -* email: *- if different from above -*

Office Address:

Office Phone: Office FAX:

Non-Prescribing Nurse / Tech / Medical Assistant:
Name: Title:

Office Contact Person: Phone:
Name: email:

Billing Contact Person: Phone:
Name: email:

Billing Address: *- if different from above -* State: ZIP:

Device Rental Fee: *$240 per month* Terms: *12 months* Device Quantity Requested:

Pricing Per patient: *$75 score & report* or *$125 score & interp. by board certified Sleep MD*

Date / /

Physician's Authorized Signature

FAX to: **(800) 260.7001**