Home Sleep Test Consent Form

Patient Name: _____ Patient DOB: _____

Patient Cell Number: _____

Patient Address: _____

By signing below, I am acknowledging and agreeing to the following statements:

- Home sleep testing monitors the airway though pressure flow analysis and chest cavity movement.
- Home sleep testing monitors pulse and oxygenation through pulse oximetry.
- Home sleep testing, while being adequate in most cases, is not the most accurate form of testing available, but is the form of testing that my insurance has approved of.
- The recording device must record at least 6 hours of data in order to be guaranteed valid. Recording times shorter than that may result in retesting.
- I understand that the device is recording and I consent to the recording of the data that the device collects.
- The device that is being left in my care is my responsibility. I agree to pay for the repair or replacement of the device as deemed necessary by the testing provider. The replacement cost of the device is $3,000.00. The insurance company will not pay for any of this cost and it is my sole responsibility.
- The testing company may bill my insurance for the services that it provides, and I agree to assign payment to the testing company.
- I am ultimately responsible for the expense of the testing. In the event that the insurance does not pay, I agree that I will pay the current cash pay price for the services rendered. The current cash price is _____.
- I have the right to review the results of my test. I would like those results sent to me in the following fashion:
    - Fax: _____
    - E-mail: _____
    - Mailed: _____

_____

_____

Patient signature: _____ Date: _____

Setup tech signature: _____ Date: _____