Institute of

Sleep Medicine

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Registration Consent

Patient Name: ____DOB:________________________________

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT

I the undersigned patient, having a condition requiring medical care, do hereby voluntarily consent to be given all inpatient/Emergency/Outpatient medical care, encompassing routine diagnostic procedures and medical/surgical treatment by an attending physician(s), assistant(s), consultant(s), or designee(s) as is necessary in their judgment. In most cases my attending physician and consulting physicians if any, are not employees or agents of Secor Sleep Diagnostic Center. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination at any Better Sleep Labs/Institute of Sleep Medicine location

FINANCIAL GUARANTEE AGREEMENT AND RELEASE OF INFORMATION

In consideration of hospitalization and all hospital services, the undersigned agrees to the following:

GUARANTEE OF ACCOUNT

I understand that I am financially responsible to Better Sleep Labs/Institute of Sleep Medicine and/or any attending physicians or their designees for all charges incurred in my treatment. If payment is not made by an insurance company or third-party payer, I understand that I am financially responsible for the charges for the services provided, even if determined by my employer, insurance company or other third-party payer to be in their judgment not necessary. I hereby authorize payment directly to Better Sleep Labs/Institute of Sleep Medicine and/or the attending physicians or their designees of all insurance benefits or payments from any other third-party payer otherwise payable to me.

RELEASE OF INFORMATION

I hereby authorize Better Sleep Labs/Institute of Sleep Medicine representatives and the attending physicians and designees to release such information from my medical record to my insurance companies, third-party payers, Medicare/Medicaid, welfare agency, my employer, or other person or agency responsible for payment for such treatment, as is necessary to obtain payment therefore, I understand that my medical record may include the Historical Patient Abstract, which is a record of diagnoses and procedures in connection with my previous admissions. Any further re-disclosures of my medical record to which I may consent may include the Historical Patient Abstract. Such information may include psychiatric and/or drug and alcohol abuse treatment records (Released subject to Chapter 5122 of the ORC and 43 CFR, part 2). Authorizations is hereby granted t release medical record information of treatment for physical and/or emotional illness, including treatment of alcohol or drug abuse to another health care provider upon my transfer for further care. I further authorize Better Sleep Labs/Institute of Sleep Medicine to fully disclose to its employees, agents, and/or to the members of its medical staff, such portions of my medical record as might be necessary for the Center to carry out its Quality Assurance and Utilization Management functions. I understand that certain aspects of my care may be discussed with my treating physician(s) in connection with the quality and utilization functions, and I consent the same.

MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to The Social Security Administration and/or the Medicare Program or its intermediaries or carriers or the Peer Review Organizations, and information needed for this or a related Medicare claim.

PERSONAL VALUABLES AND EQUIPMENT

I understand that Better Sleep Labs/Institute of Sleep Medicine is not responsible for my money, credit cards, jewelry or other valuables that I bring with me. I release the center from any responsibility for and injury, property damage or loss arising from the use of my own electrical or non-electrical equipment.

PERMISSION TO BE PHOTOGRAPHED

I do voluntarily consent to being photographed and/or videotaped during my study for the purpose of diagnosing my condition and for identification purpose.

Patient Signature:

____Date:______________________________

Authorized Representative Signature

____Date:______________________________

Witness Signature:

____Date:________________________________

Patient is unable to sign because:

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