PLEASE WEAR FOR 2 NIGHTS

Please fill out the attached paperwork and return with machine.

If you have any technical issues after our regular business hours

Monday-Friday 9:00am to 5:00 pm please call 1-877-710-6999.

There is a booklet with instructions included.

Patient Name:_____
(Please Print)

HOME STUDY INFORMED CONSENT

Please read the following information to familiarize yourself with the type of test you will be having as a patient of the SleepBetter Institute.

To enable the test to be as accurate as possible, you need to be familiar with the operation of the equipment, so if you have any questions please call us. You have been given an instruction booklet with step by step instructions as well as a phone number for 24 hour customer support. By signing the agreement you are stating that you were given instructions for the use of the machine and understand how to operate it properly. You should continue to take any medication prescribed by your doctor unless told otherwise.

You are responsible for the equipment once it leaves the SleepBetter Institute. Please take good care of the equipment; it is sensitive to "bumps" and extreme temperatures, such as leaving it in the car for sustained periods. By accepting this equipment, you also agree that it will be returned in good working condition. If equipment is visibly damaged or not returned you will be responsible to pay $1200.00 for replacement.

We have taken a credit card number from you before shipping your machine. Please return the equipment to The SleepBetter Institute on the next business morning (following your study) unless other arrangements are made. Your prompt return of the Home System will enable us to furnish your physician with the results quickly. If we do not hear from you or we cannot see that the machine has been sent back we will start charging your credit card $50.00 a day until we hear from you or receive the machine back or you reach the $1200 replacement price. If you send the machine back without being used you will also be charged $300 because we are not able to bill your insurance. As a patient it is in your best interest to know and understand your insurance coverage and benefits. The SleepBetter Institute will make all efforts to process your insurance claims. If for any reason the insurance company denies payment it is your responsibility for payment on your account for all services rendered. All payments/co-payments are due at the time of service. If you are unable to make payment you must have prior arrangements with The SleepBetter Institute. If for any reason your account is sent to collections you will be responsible for fees and interest accrued on understand the above.your account. You will also be responsible for any attorney fees that may apply. You will be responsible for all returned checks and charged a $25.00 return check fee. By signing at the bottom of this agreement you are assigning and transferring to The SleepBetter Institute all insurance benefits payable by your insurance company for the cost of all services rendered by The SleepBetter Institute.

I have read and

_____ _____
Signature of Patient Date

_____ _____
Signature/Relationship to Patient Date

Reason for patient's inability to sign: _____

_____ _____
Signature of Witness Date

Please complete the reverse side-→

Name: _____

Weight_____Age_____Gender_____Neck Size_____

Height_____feet_____Inches Date of Birth_____

SSN:____-___-_____(this is needed for billing purposes)

Emergency Contact:_____

Street address: _____

City: _____State:_____Zip code:_____

Home phone:_____Cell phone: _____

Primary Insurance: _____

Insurance ID: _____

Secondary Insurance: _____

Insurance ID: _____

Employer:_____

Would you like your results emailed to you? Yes No

Email address: _____

Please complete the reverse side-→

Have you been diagnosed or treated for any of the following conditions?

High Blood pressure:	Yes	No	Stroke:	Yes	No
Heart Disease:	Yes	No	Depression:	Yes	No
Diabetes:	Yes	No	Sleep Apnea:	Yes	No
Lung Disease:	Yes	No	Nasal oxygen use:	Yes	No
Insomnia:	Yes	No	Restless leg syndrome:	Yes	No
Narcolepsy:	Yes	No	Morning Headaches:	Yes	No
Sleeping Medication:	Yes	No	Pain Medication:	Yes	No

Circle one of the following for each question:

Frequency:	0-1 times/week	1-2 times/week	3-4 times/week	5-7 times/week
Never	Rarely	Sometimes	Frequently	Almost Always

On average in the past month, how often have you snored or been told that you snored?

Never Rarely Sometimes Frequently Almost Always

Do you wake up choking or gasping?

Never Rarely Sometimes Frequently Almost Always

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

Never Rarely Sometimes Frequently Almost Always

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

Never Rarely Sometimes Frequently Almost Always

Please complete the reverse side-→

Epworth Sleepiness scale

How likely are you or doze or fall asleep in the following situations?

0= no chance of dozing
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Sitting and reading: ☐

Watching TV: ☐

Sitting inactive in a public place (e.g a theater or a meeting: As ☐

a passenger in a car for an hour without a break: ☐

Lying down to rest in the afternoon: ☐

Sitting and talking to someone: ☐

Sitting quietly after lunch without alcohol: ☐

In a car, while stopped for a few minutes in traffic: ☐