MILLENNIUM SleepLAB
Testing At Home

PATIENT REGISTRATION FORM

NIGHTS_____

DEVICE #_____

PATIENT DEMOGRAPHICS

Name: _____ Sex: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____ Cell phone: _____

Email: _____

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 at the top of this page or one of their contracted providers 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 in or out of network. It is my responsibility to notify the organization of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives 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 or NightOne recorder. I also certify that by receiving the recorder, the test was performed on me. I understand that if I chose not to complete the home study and send the equipment back without using the recorder for the number of nights noted above, I will be charged a $100 *per night* service fee. Further, if the device is not returned on _____, I will be charged an additional $100 *per night* not covered by insurance unless other arrangements are agreed upon by Millennium Sleep Lab. In each case these fees will be charged to your credit card on file.

I understand that Millennium Sleep Lab reserves the right to pursue criminal/legal action against me if said recorder is not returned, or is returned damaged. I understand that I will be charged the replacement cost of the Alice PDx or NightOne recorder, in the amount of $3500.00.

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.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND INSTRUCTIONS

By signing the below, I acknowledge that I have been provided a copy of Notice of Privacy Practices.
I acknowledge that I have received instruction on how to properly apply and turn on the portable sleep recorder.

Patient Signature:

_____ Date: _____

Delivery made by: _____ **Date/Time:** _____