ISLAND
SLEEP TESTING

Home Sleep Test (HST) Instructions

1. Your physician has ordered an unattended home sleep test (HST) to diagnose or rule out sleep apnea. This test cannot diagnose any other sleep disorders.

2. This device cannot be used at the same time as a PAP device or nocturnal oxygen. If you must sleep with a PAP device or oxygen, please speak with your doctor before testing.

3. Island Sleep Testing will verify your insurance coverage for this test. If requested, we can provide an estimate of your financial responsibility. For exact coverage information, you must contact your insurance provider.

4. Please test on the night that you first receive the device. It is important that you complete your test and return the device as scheduled. If for any reason you are unable to test, please contact Island Sleep Testing immediately at (808) 784-2588.

5. Please contact your referring physician in 7-10 business days for your results and recommendations.

6. Based on the results of your test and the recommendation of your physician, you may require additional service such as an in-center sleep study or PAP device set-up. Please discuss next steps with your physician.

560 N Nimitz Hwy, STE 126B-1, Honolulu, HI 96817
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PATIENT INFORMATION			
NAME: Last	First	Middle	
Birthdate: / /	Age:	Sex: ____ M ____ F	SS#: XX–XXX- __ __ __ __
___ Single ___ Married ___Widowed ___Separated ___ Divorced		Home Phone:	Cell Phone:
Billing Address			Email:
Occupation:			If Military Specific Grade:
Employer:			
Employer Phone:			Length of Employment:
Spouse:		Spouse Phone:	
Spouse's SSN#:		Spouse Email:	
IF THE PATIENT IS A MINOR, please complete the following:			
Parent or Guardian's Name:			Relationship to patient:
Mailing Address:			
Home Phone:	Cell Phone:		Work phone:
IN CASE OF EMERGENCY			
Name of emergency contact:			
Relationship:	Home Phone:		Cell Phone:
MEDICAL INSURANCE INFORMATION			
Name of Primary Insurance:		Subscriber #:	
Subscriber:		DOB:	Sex: __ M __ F
Name of Secondary Insurance:		Subscriber #:	
Subscriber:		DOB:	Sex: __ M __ F
PHYSICIAN INFORMATION			
Referred by:		Primary Care MD:	

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGMENT OF RESPONSIBILITY FOR PAYMENT FOR PHYSICIAN SERVICES

Do you authorize the release of medical information about you to anyone such as your spouse, children, etc.?
☐ No. ☐ Yes. If Yes, to whom?_____Relationship:_____

Do you have a telephone answering machine or voice mail? ☐ No. ☐ Yes.
If yes, may we leave messages on the answering machine or voice mail? ☐ No. ☐ Yes.

I hereby give consent to Island Sleep Testing to provide whatever treatment is deemed necessary.
I authorized any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these services.

I request that payment of authorized Medicare and other insurance benefits be made to me on my behalf to the physician for any services furnished me by that physician. This assignment will remain in effect until revoked by me in writing.

I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted. I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Signature _____ Date _____

Print:_____ (circle) Patient Parent Guardian

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Terms and Conditions of Service
{Read Carefully Before Signing}

1. Consent to Medical Procedures
Patient consents to the procedures, which may be performed by Island Sleep Testing in connection with Patient's diagnosis or treatment.

2. Release of Information
Patient hereby authorizes Island Sleep Testing. to furnish to Patient's insurance company all information that the said party may request concerning Patient's diagnosis or treatment. Furthermore, Patient Island Sleep Testing. to release Patient's sleep study results and report to other caregivers for the purpose of further diagnosis or treatment.

3. Assignment of Benefits

- Your insurance company may send our payment directly to you. Although every effort is made on our part to streamline the payment process with your insurance carrier, there are times when you may receive a check for the services we provided. Should you receive payment, we are requesting that once the check has cleared your financial institution, you contact our business office at the toll free number listed below to settle your account balance. Please keep in mind the amount owed may be more than the face value of the check you receive. This will be due to any co-pays, co-insurance and/or deductibles applied to the claim. Take the time to review your explanation of benefits that accompanies the payment carefully for the total amount owed to our office. Failure to settle any unpaid balance may result in your account being forwarded to a collection agency. **INITIAL:_____**
- Patient understands that Patient is responsible for understanding his/her individual insurance policy and benefits prior to seeking services.
- Patient recognizes that Island Sleep Testing will bill and attempt to collect from Patient's insurance, as courtesy to Patient and that Patient is financially responsible to Island Sleep Testing for all charges for services rendered. Patient understands that this may lead to Patient receiving a bill, which may include any deductible, co-payment and co-insurance and agrees to pay such bill. **INITIAL:_____**
- If Patient is an HMO patient, Patient understands that Patient is responsible for any amount attributed to co-pay; deductible or non- covered services, should that apply to Patient's plan. **INITIAL:_____**

4. Automated Collections Calls
I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive autodialed, pre-recorded calls, or both, from or on behalf of Island Sleep Testing at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, pre-recorded calls, or both, and understand that my consent to such calls is not a condition of purchasing any goods or services.
INITIAL:_____

5. Authorized Signature
Patient certifies that he/she has read this form, understands and agrees with it fully. If this form is signed by anyone other than Patient, then the signee certifies that he/she is Patient's legal representative or is duly authorized by Patient (as the patient's representative) to execute this form for and on behalf of patient and to accept its terms for and on behalf of Patient who shall be bound thereby.

Signature of Patient/Patient Representative: _____

Print Name of Patient/Patient Representative: _____ Date: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

The rights of patient(s) include, but are not limited to the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Be given information about your rights for receiving testing and treatment.
- Receive a timely response to any reasonable requests you may make for services.
- Be given information about Island Sleep Testing's policies, procedures and charges for services.
- Choose your medical providers.
- Be given appropriate and professional quality testing & treatment to you.
- Exercise your rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, the source of payment or utilization of services.
- Be free from physical and mental abuse and/or neglect.
- Be given proper identification by name and title of everyone who provides any medical services to you.
- Be given the necessary information so you will be able to give information consent for your service prior to the start of any service.
- Be given complete & current information concerning your diagnosis, treatment, risks, alternatives and prognosis as required by your physician's legal duty disclose in terms and language you can reasonably be expected to understand.
- Participate actively in decisions regarding the medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Confidential treatment of all written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home. Written authorization of the member or authorized legal representative shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except as required by law.
- Review your clinical records at your request.
- Voice your complaint with and/or comment change in medical services and/or staff without being threatened, restrained, and/or being discriminated against.
- Full consideration of privacy concerning your medical care program.
- Case discussion, consultation and treatment are confidential and should be conducted discreetly and to be advised as the reason for the presence of any individual.
- Participate in the consideration of ethical issues that arise in your care.
- Be informed of the actual dollar amount of charges, if any, for which you may be liable.
- Have access, upon request, to all bills for services you have received regardless of whether the bills are paid out-of-pocket or by another party.

The responsibilities of patient(s) include, but are not limited to the responsibility to:

- Give accurate and complete health information concerning your past illnesses, hospitalization, medication, allergies, and other pertinent items.
- Assist in developing and maintaining a safe and cooperative environment for care & services to be provided
- Refrain from inappropriate behavior during the procedure, including but not limited to any sexual behavior or aggressive behavior.
- Inform Island Sleep Testing when you will not be able to keep your appointment.
- Participate in the development and update of your treatment plan.
- Follow direction in regards to your testing and treatment.
- Request further information regarding anything you do not understand.
- Contact your physician whenever you notice any unusual feelings or sensations during your plan of service/treatment.
- Contact your physician whenever you notice any change in your condition.
- Give information regarding any concerns and problems you may have to Island Sleep Testing staff member.
- Contact Island Sleep Testing prior to any change of telephone number or address.
- Patient agrees to meet all his/her financial obligations and responsibilities agreed upon with the organization.

Patient Signature:_____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Island Sleep Testing Notice of Privacy Practices and HIPPA policy with the effective date of January 1st, 2016. I will notify Island Sleep Testing of any special requests that I may have with regards to my private health information.

_____
Signature of Patient/Patient Representative

_____
Print Name of Patient/Patient Representative

_____
Relationship to Patient

_____
Date

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HST Device Patient Liability Form

I, _____, agree to return the equipment to the Coastal Dream Docs Inc. (DBA, Island Sleep Testing) facility located at: _____ *(Facility address)* on_____ *(Return date).*

I acknowledge that I will be charged a **service fee of $250.00 per day**, if the HST device is withheld after the agreed upon return date. In addition to the service charge, I acknowledge that failure to return the HST device within **3 business days** of the return date serves as authorization for the Coastal Dream Docs Inc. (DBA, Island Sleep Testing) representative to bill me in the amount of $3,500.00 for the purchase of the device.

Print Name: _____

Signature: _____

Date: _____

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