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## Disclosures and Authorizations

Name: \_\_\_\_\_

(please print name above and initial each section)

### **Patient Consent for Treatment**

\_\_\_\_\_ I am requesting USA Sleep Diagnostic Mobil Service, LLC (“USA Sleep”) to test me for possible sleep disorders and I authorize USA Sleep to provide such tests as set forth in the physician order.

\_\_\_\_\_ I understand that photographs, video, digital or other images may be recorded to document my care and I explicitly provide my consent. I understand USA Sleep retains the ownership rights to any such recorded images and I understand I am able to view or obtain copies. I understand these recorded images will be stored in a secure manner to protect my privacy as part of my medical record and will be kept for the time required by law.

\_\_\_\_\_ I acknowledge I have consulted my physician and understand the nature of the test(s) and consent to such sleep tests.

### **Patient Assignment of Benefits Agreement**

\_\_\_\_\_ I authorize direct remittance of payment of all insurance or Medicare benefits to USA Sleep for all covered services, and I authorize USA Sleep to act as my Designated Representative concerning all aspects of insurance claim filing, including, but not limited to, appeals for products or services rendered by USA Sleep. I understand and agree that my Assignment of Benefits will have continuing effect for as long as I am receiving services from USA Sleep. I authorize my insurance company to mail ALL PAYMENTS directly to USA Sleep.

### **Receipt of Notice of Privacy Practices, Patient Rights and Responsibilities, and Provider Performance Standards**

\_\_\_\_\_ I have received and reviewed the attached Notice of Privacy Practices, the Patient Rights and Responsibilities, and the Provider Performance Standards; I understand my rights as stated in these documents.

I have read all of the above and have initialed in the appropriate locations acknowledging I have read and I understand each section. My initials and signature represent my unqualified acceptance and acknowledgement of each of the above statements. I authorize a copy of this form to be used in place of the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

