HOME SLEEP TEST CONSENT AND RELEASE FORM

We are the HST provider you have chosen. Under your doctor's order (or your discretion), we are providing you with the HST device. It is very important to us that you understand and consent to your financial responsibility and duty to return the HST device. It is also important that you understand your privacy rights. Please sign this Consent Form only after you fully understand your rights and responsibilities, and all of your questions have been answered.

YOUR RESPONSIBILITIES

HST. If you have any problems, you must call us immediately at **864-315-0928.** We are always here to answer your questions.

Use of the HST Device. You are the only person authorized to use this HST device and take the home sleep test.

Financial Responsibility. Payment in full is required before we loan you the HST device.

Device Return. We are loaning you the HST device. You must return it to us within 3-days from the date of receipt. If you do not return the HST device to us within the specified timeframe, we will bill you $250 per day until the device has been shipped.

YOUR RIGHTS

Privacy Practices. We have made available our Notice of Privacy Practices (***NPP***), which explains how we may use and disclose your health information.

ACKNOWLEDGEMENT: By signing below you acknowledge that: (1) You will not permit any other person to use the HST device or take the home sleep test; (2) We do not diagnose, write prescriptions, or act as your physician; (3) You have downloaded our NPP (HIPPA agreement), and (4) You have read and understand the terms of this Consent Form.

You do not have to sign this Consent Form. If you do not sign, we will not loan you the HST Device.

Printed Name of Patient: _____ Date of Birth: _____/_____/_____

_____ Date: _____/_____/_____

Signature of Patient or Patient's Legal Representative

_____ _____

Printed Name of Legal Representative (If applicable) Witness

Best telephone number to reach me: _____

Credit Card Authorization Form

Please complete all fields.
This authorization will remain in effect until the home sleep testing device is returned

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ Three Digit Code on Back: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases if the home sleep testing device is not returned within 3 days. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date