PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____

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

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

INSURANCE INFORMATION

Primary Insurance Name: _____ ID#: _____ GRP#: _____

Secondary Insurance Name: _____ ID#: _____ GRP#: _____

ASSIGNMENT OF BENEFITS/STATEMENT OF TEST AUTHENTICITY

I, the undersigned, hereby request payment for authorized insurance benefits be made on my behalf to Millennium Sleep Lab LLC, a contracted partner of Sleep Impressions LLC, for services and equipment provided by that organization. I assign and convey directly to Millennium Sleep Lab LLC, as my designated authorized representative, all medical benefits and insurance reimbursement otherwise payable to me for all services, therapy, and equipment provided by the organization, regardless of managed care network participation status.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits, in or out of network. I confirm that the insurance information above, for both primary and secondary insurance, is correct, and 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 acknowledge that I have been provided a copy of the Explanation of Fees and that based on information from my insurance company my estimated responsibility will be $_____, but I understand that this is not a guarantee. I understand by signing below that I am accepting financial responsibility for all payment for products and/or services received.

I understand that once the custom oral appliance device is fabricated, even if I chose not to receive or use the device, the product and service is still being rendered, a claim will be submitted to my health care insurer, and I will be financially responsible as outlined above.

MEDICAL RELEASE

I, the undersigned, authorize Millennium Sleep Lab LLC and Sleep Impressions LLC 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, dentist, and the DME provider.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

By signing the below, I acknowledge that I have been provided a copy of Notice of Privacy Practices.

INITIAL _____

General Release of Liability and Assumption of Risk

I, the undersigned, understand that failure to comply with treatment of sleep apnea can result in several physical and social issues including but not limited to: coronary artery disease, congestive heart failure, diabetes, hypertension, stroke, increased motor vehicle accidents, and excessive sleepiness.

As Millennium Sleep Lab LLC and Sleep Impressions LLC cannot ensure success of any treatment or guarantee that any patient will comply with treatment, I hereby waive any rights that I, my heirs and assigns might have to seek legal redress for any damage, physical or monetary, that I might sustain as a result of my treatment or my failure to comply with treatment of sleep apnea. Therefore, I release the organizations, their affiliates, their employees, and their contractors, from any and all liability associated with my treatment and I personally assume all risk associated with my care.

I hereby agree to hold these organizations, their affiliates, their employees, and their contractors harmless for any damages that might result from my sleep apnea treatment.

Patient Signature:

_____ Date: _____

Print Name: _____