Pro Sleep Care
TODAY'S SLEEP SOLUTION

Corp Address: 22330 Hawthorne Blvd. Torrance, CA. 90505 Suite 214 Tel: 760.779.1444 Fax: 888.816.5060

Patient Information

First Name_____ Middle_____ Last Name _____

Street Address _____City_____ State_____ Zip_____

Home Phone _____ Work/Cell Phone _____ Email_ _____

Employment Status__Full time__Part Time__Other Employer Name _____

Date of Birth _____ Soc Sec # _____ Gender __Male __Female

Marital Status __Married__Single__Divorced__Other Spouse Name_____

Medical Doctor Name _____ Phone_____Fax_____

Emergency Contact name _____Relationship _____Phone _____

Medical Insurance Information (Please include a copy of front & back of insurance card)

Primary Insurance Name _____**Insurance Phone#**_____

Full Name of Insured _____ Relationship to Patient _____

Insured Birth Date _____Insured Employer Name _____

Primary Insurance I.D. #_____Policy/Group # _____

Secondary Insurance Name _____**Secondary Ins. Phone#**_____

Full Name of Inured _____Relationship to Patient_____

Insured Birth Date _____ Insured Employer Name _____

Secondary Insurance I.D. # _____ Policy/Group #_____

Patient Notices and Acknowledgements

Assignment of Benefits: I request that payment of authorized insurance benefits (if any) be made on my behalf to Pro Sleep Care ("PSC") for any services furnished to me by PSC. I hereby authorize PSC to release to the applicable insurer (if any) and its agents any medical information needed to determine the scope of benefits payable for rendered services. I acknowledge that I will be responsible for any deductible, coinsurance and/or co-payment amount that my insurance may require.

Privacy: I hereby authorize PSC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me in order to carry out the provision of diagnostic sleep services, durable medical equipment/oral appliance and payment for such services. I have received a copy of the Notice of Privacy Standards (HIPAA) which more fully describes the uses and disclosures that can be made of my individually identifiable health information in order to carry out the provision of provided services and payment for such services. I understand that I may revoke this consent at any time by notifying PSC in writing, but if I revoke my consent, such revocation will not affect any actions that PSC took before receiving my revocation. I understand that PSC has reserved the right to change its privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that PSC restricts how my individually identifiable health information is used and/or disclosed in order to carry out the provision of Sleep Testing, Durable Medical Equipment (DME) and payment for such services. I understand that PSC does not have to agree to such restrictions, but that once such restrictions are agreed to PSC must adhere to such restrictions.

Liability Release: I authorize access to all of my insurance information and medical records necessary for billing the related healthcare services. I hereby give permission to release any medical information or insurance information in order to file any insurance claims. I release Pro Sleep Care and its agents from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on me or my dependant to be paid directly to the provider and payment for services on me or my dependant behalf are my sole responsibility. I understand that a separate bill for interpretation may be sent for the interpreting physician.

Receipt of Documents: I hereby acknowledge receipt of Pro Sleep Care's Notice of Privacy Practices (HIPAA).

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

I certify that I have read and understand the above information; understand my responsibilities; and have access to a copy of this form.