Tel: 1 (760) 779-1444
Fax: 1 (888) 816-5060

Patient Information

First Name: ___________________ Middle: _____________________ Last name: ________________________________

Street Address: ____________________________ City: _____________________ State: _____ Zip: _____________

Home Phone: ______________ Work Phone: ______________ Ext.: ______ Cell Phone: _______________

Employment Status Full time___Part Time_____ Employer Name: ____________________Email: ___________________

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)

Patient or guardian is responsible for notifying our office of any changes to demographics and billing information.

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 a change 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 PSC must adhere to such restrictions.

Liability Release: I authorize access to all my insurance information and medical records necessary for billing the related healthcare services. I hereby give permission to release any medical 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 to me or my dependent to be paid directly to the provider and payment for services on me or my dependent 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 I have read and understand the information; understand my responsibilities; and have access to a copy of this form.