Mountain Sleep Diagnostics, Inc.
Informed Consent for Procedure/Treatment
(To be Completed for Medical Records to be Released)

Proposed Procedure/Treatment: In Home Polysomnogram (Sleep Study)

Request for Provision of Service: I understand that by signing this consent, I indicate my intent to purchase health care services from Mountain Sleep Incorporated and hereby give permission to Mountain Sleep Diagnostics Incorporated and its agents to perform said testing.

Risks and Benefits: The risks and benefits of the procedure have been explained to me, as well as the risks and benefits of refusing the procedure. Benefits of having in home testing done are to gather information for a sleep related diagnoses. This is a non-invasive procedure and risks are minimal. There is a risk of allergic reaction to adhesives if used.

Medical Information Authorization: I hereby authorize my physician/hospital to furnish to an agent of Mountain Sleep Incorporated any and all records pertaining to my medical history, mental or physical condition, services rendered or treatment needed to process claims.

Release of Medical Information to Insurance Carriers:I hereby authorize Mountain Sleep Incorporated to furnish to my insurance carrier(s) or its agent(s) any information concerning my medical history, mental or physical condition, services rendered or treatment need to process claims.

Assignment of Insurance Benefits: I assign and transfer to Mountain Sleep Incorporated any and all rights to receive any insurance benefits otherwise payable to me for provided products or services. I authorize my insurance company to furnish to any agent of Mountain Sleep Incorporated any and all information pertaining to my insurance benefits and status of claims required by my insurance program. I acknowledge that I am responsible for my copayment, unmet deductible amount or other amount not covered by my insurance program. All out of pocket balances quoted are estimates and cannot be guaranteed until your insurance company processes your claim. You will be responsible for any unpaid balance by your insurance company.

Acknowledgment of Demonstration of Equipment Use: I acknowledge that I was either instructed in person, by video link on the provided instructions or by phone on how to apply the equipment and how the equipment operates. I was also instructed that there is an RPSGT or Respiratory Therapist available 24 hours a day for any in home testing equipment needs.

Acknowledgment for End of Year Policy: I acknowledge that because home sleep studies are performed without a technician present, there is no assurance the test will be successful or meet the requirements needed and a repeat study may be needed. I am aware if testing must be repeated for any reason; I will be responsible for meeting the reset of my deductible for any scheduling after the start of the New Year. I understand that MSD must bill my Insurance for the day of the SUCCESSFUL study.

I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or process.

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Printed Name Authorized Signature

_____ Today's Date