AWAKEN 2 SLEEP

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PATIENT INTAKE FORM

PATIENT NAME: _____ DOB:_____

Your doctor has ordered a Home Sleep Test (HST) to assess your airway health during sleep. The testing device consists of a pulse oximeter, respiratory effort belt and nasal cannula. Upon authorization by your medical insurance company (if applicable), your test unit will be shipped to your address on file via Fedex Express. Instructions will be included in the pack.

DATE: Next available unit will be shipped unless a specific date is requested: _____

You will need to perform the prescribed 2-night Home Sleep Test within **72 Hours** after receiving the device. Simple instructions and prepaid Fedex return label are provided.
To avoid a $25/ day late fee, you must contact us if you need an additional day to test. Devices returned with no recorded data will be subject to a $75 restocking fee. If the device is not returned within 30 days or is returned in damaged condition, a $4,000 device replacement fee will be assessed.

(Initial) _____ I authorize the use/ release of this form and any medical information necessary to process my claims on all insurance submissions.

(Initial) _____ I will permit a copy of this authorization to be used in place of the original

FEE: Your copay for this test is $347

CREDIT CARD AUTHORIZATION

Cardholder Name:_____ Expiration: _____

Account Number: _____ CVV: _____

(Sign) _____ _____
Signature **Date**

I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services, including copays, late fees, restocking fees, device replacement fees and insurance reimbursement amounts described above. I understand my credit card will be stored in a PCI-DSS compliant format "on file" for said charges. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.