The Vine MEDICAL CENTER & Sleep Lab for Adults & Children

PATIENT SERVICE AUTHORIZATION AND PLAN OF SERVICE FOR SLEEP TESTING

ACCREDITED FACILITY MEMBER

Patient Name: _____ DOB: Date: _____Date:_____

PATIENT SERVICE AUTHORIZATION

PATIENT INITIALS

_____**Authorization/Consent for Care/Service:** I authorize The Vine Medical Center and its affiliates, to provide sleep testing services as prescribed by my physician. I understand that my physician is referring me to The Vine Medical Center for this diagnostic testing and consent to this referral. I understand that I have the right to select a service provider other than The Vine Medical Center.

_____I have ***NO*** known or suspected history of skin sensitivities or allergies to cosmetics, lotions, adhesives or latex products.

I ***DO*** have a history of skin sensitivities or allergies to cosmetics, lotions, adhesives or latex products.

_____**Assignment of Benefits/Authorization for Payment**: I hereby assign all benefits and payments to be made directly to The Vine Medical Center, and/or the Board-Certified Sleep Physician who provides interpretation services furnished to me in conjunction with my care. I understand that Center, may have a fee-for-service agreement with my physician to provide interpretation services, and I hereby authorize Center to seek such services and make such payments. I understand that I am responsible to provide all necessary information and ensure that all preauthorization and enrollment requirements are fulfilled to include reporting any policy changes to Center within 30 days of the event. I have been informed by Center of the medical necessity for the services prescribed by my physician. I understand that in the event that there is a lack of coordination of benefits or if the payment is assigned directly to the patient or if services are deemed not medically necessary, payment may be denied and I may be fully responsible for payment. I also understand that the physician may bill for professional interpretation services that he/she renders.

_____**Release of Information:** I hereby request and authorize TVMC, the prescribing physician, hospital, and any other holder of information relevant to service, to release information upon request, to Center, any payer source, physician, or any other medical personnel or agency involved with service. I also authorize Center to review medical history and payer information for the purpose of providing services.

_____ **Communication via E-mail/Phone:** I consent to the communication of account information via the personal e-mail address and/or phone number provided at the time of registration, and understand that I may opt out any time. I understand my e-mail/phone number is confidential and will not be shared with any outside organization. Communication may consist of future appointment information, insurance billing status, and account balance information for example. The results of any studies will require a separate authorization for e-mail communication containing protected health information (PHI).

_____ **Cancellation/No Show:** Please give us notice of cancellation 48hrs. Prior to their scheduled sleep study. If a test is cancelled after 48 hrs time period or you fail to show up to your scheduled sleep study, you will be charged a $250.00 cancellation fee. This is not covered or billed to your insurance company. The patient is solely responsible for any and all applicable cancellation fees. Please be aware that we report to all applicable credit bureaus and employ the services of legal collection agencies.

_____ **Grievance/Complaint Reporting:** I acknowledge that I have been informed of the procedures to file a grievance/complaint should I become dissatisfied with any portion of my services. I understand that I may file a grievance/complaint without concern for reprisal or discrimination at any time.

PLAN OF SERVICE

Plan of Services/Actions Provided: Perform the patient assessment, review the service(s) prescribed by the physician and provide patient education of sleep testing procedures and instructions for obtaining follow-up services and study results.

Provide an opportunity to answer any additional questions the patient or the patient's representative may have regarding this authorization or the services. Proceed to conduct the ordered services.

Patient Signature: _____ **Date: _____**

Signature of Authorized Patient Representative: *Relationship:* _____

If the patient is a minor or is otherwise unable to sign this authorization, the signature of a parent, guardian or other legal representative is required.

Technologist/ Representative Signature: _____ Date: _____