GUAM SLEEP CENTER

535 Marine Corps Dr, Unit 1A, Tamuning, GU 96913
T: (671) 647-6669 | F: (671) 647- 6277 | www.guamsleepcenter.com

ACCREDITED MEMBER CENTER

CONSENT FOR POLYSOMNOGRAPHY

I understand that I will be undergoing a sleep study. Electrodes and other sensors will be attached to my body. The tape used may cause discomfort during removal and the tape or cream used may cause redness at the site of attachment. Lotion or cream is available for the redness if requested. During the study, I will be free to roll over in bed, but will have to ask for assistance to get out of bed (head box has to be disconnected). I will be observed and videotaped on closed circuit TV throughout the study. There are no significant risks to me from the test. I understand the reason for the test and the procedure has been explained to me.

PERMISSION TO PHOTOGRAPH AND/OR RECORD VIDEO AND/OR AUDIO

I, ____,
Patient/Guardian (Print)

hereby authorize the taking of photograph(s) and/or recording of video and/or audio(s)

of ____,
Name of Patient (Print)

by Guam Sleep Center, or their representative, with the understanding that such photograph(s), audio, and/or video recording(s), may be used to assist in evaluating my sleep, for clinical or educational purposes, or in the event of legal action. Guam Sleep Center and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio and/or video recording(s) for the purposes mentioned above.

Any recordings obtained during the course of the sleep study will remain confidential and will be considered a protected portion of my medical record.

☐ Check here if you do NOT authorize use for educational purposes. Any use of the video for medical education will not identify you by name.

________________________________	____________________	__________
Signature (patient or guardian)	Relationship to Patient	Date

________________________________	__________
Witness's Signature	Date

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AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP
ACCREDITED MEMBER CENTER

HIPAA PRIVACY NOTICE

With this consent, the doctors and his/her staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With this consent, the doctor and his/her staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent, the doctor and his/her staff may mail or fax to my home, referring physician or other designated location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements.

With this consent, the doctor and his/her staff may speak and release my PHI to the following spouse, family member, relative, friend or parties listed below.

NAME	RELATIONSHIP	NAME	RELATIONSHIP

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This consent covers the period of time from my first visit until I revoke my consent in writing. I release the doctor and staff from all legal responsibility that may arise from this authorization. **By signing this form, I am consenting to the doctor and his/her staffs use and disclosure of my PHI to carry out TPO.**

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I have read the Notice of the Uses and Disclosures of Protected health Information. I was informed that I might also obtain a printed copy of the notice from your receptionist. I hereby acknowledge that I viewed a copy of the notice.

____________________________ Signature (patient or guardian)

______________ Date

____________________________ Patient's Name (Print)

____________________________ Legal Guardian's Name (Print)

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PAYMENT POLICY

Please read this policy explaining patient responsibility for services rendered, initial each numbered paragraph in the space provided, then sign in the space provided. A copy will be provided to you upon request. Payment is due at the time of service. For your convenience, we accept cash, check, and credit card (MasterCard and Visa) payments.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment is due in full at the time of service. It is important that you know your insurance benefits. Please contact your insurance company with any questions you may have regarding your coverage. If you do not have insurance, payment in full is due at the time of service. ______
2. **Co-payments, Co-insurances, Cost-shares, and Deductibles.** You will be financially responsible for all co-pays, co-insurances, cost-shares, and/or deductibles at the time of service, depending on your insurance plan/policy. ______
3. **Non-covered Services.** Please be aware that some or all of the services you receive may be a non-covered benefit or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit. ______
4. **Proof of Insurance(s).** All patients must complete our patient registration form before service is rendered. We must obtain a copy of your driver's license and current valid insurance(s) to provide proof of insurance(s). If you fail to provide us the correct insurance information in a timely manner, you may be financially responsible for your account balance. ______
5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. ______
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. ______
7. **Non-payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. If you are unable to pay the full balance please inquire about payment arrangements. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency if no prior arrangements have been made. ______
8. **Interest for Unpaid Charges.** Any unpaid charges shall be paid promptly by the patient or responsible party (undersigned) in accordance with terms of this agreement. We, Guam Sleep Center, may add one and one half percent (1.5%) per month to any balance owed. In the event of default, you agree to pay reasonable collection charges, not to exceed 30% of the unpaid balance at the time the account is assigned to a collection agency, and/or attorney fees, court cost and post judgment interest.
9. **Returned Check.** Our fee for returned checks is $30.00. If your check is returned we will require that future payments be made by cash, cashier's check or credit card. ______
10. **Minors.** We will look to the adult accompanying a minor for payment of all services rendered to minor patients. ______

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

I have read and understand the payment policy and agree to abide by its guidelines.

____ ______________

Signature (patient, guardian, or responsible party) Date