# SOUND SLEEP HEALTH
## Patient Information

| Date: | | | |
|---|---|---|---|
| **First Name:** | **MI:** | **Last Name:** | |
| Address: | | City/State/Zip: | |
| Date of Birth: | Age: | Gender: Male ❑ Female ❑ | |
| Social Security #: | | Marital Status: S ❑ M ❑ D ❑ W ❑ | |
| Home Phone: | | Cell Phone: | |
| Patient Employer: | | Work phone: | Ext: |
| Occupation: | | | |
| Email: | | Ok to communicate by email? Yes ❑ No ❑ | |
| Spouse/Guardian: | | Spouse Guardian employer: | |

| Primary Insurance: |
|---|
| Insurance Co-pay (please pay today, see reverse for information): |
| Subscriber Name: |
| Insurance ID #: |
| Group #: |
| Secondary Insurance: |
| Subscriber Name: |
| Insurance ID #: |
| Group #: |

| **Referring Physician:** |
|---|
| **Primary Care Physician:** |
| **Referred by (if other than a Physician):** |

| Please list the name of someone who we may contact in case of an emergency | | |
|---|---|---|
| Name: | Relationship: | Phone: |

****I authorize Sound Sleep Health to release my medical records to my insurance company and other medical providers. ****

________________________________________ Date: __________________

(Signature)

*******PLEASE ALSO READ AND SIGN THE SECOND PAGE OF THIS FORM*******

**THANK YOU**

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We will bill your insurance for you, providing that you supply Sound Sleep Health **with complete and current billing information.** Any balance after insurance has paid is your responsibility and is due and payable upon receipt of our statement.

Insurance co-pays are due at the time of service.

Many insurance companies **require referrals from your Primary Care Doctor prior to your appointment with us.** If a referral is required, please make sure that your Primary Care Doctor issues one to us before your appointment.

**Some insurance policies do not include coverage for sleep disorders.** Please call your insurance carrier **before your appointment** to check your benefits so that you have advance knowledge of your financial responsibility.

Office visits and sleep studies involve a large commitment of resources on our part. If you cannot come in for an appointment or study, please contact us **at least 24 hours in advance** to allow us to fill your slot.

**If you do not show, or call to cancel your appointment at least 24 hours in advance there will be a $25 no-show/cancellation fee. A $75 no-show/cancellation fee applies to the sleep study.**

Please contact your pharmacy directly for prescription refills, and allow 48-72 business hours for processing.

**Please carefully read the following statement, then sign and date it:**

I have read and I understand the above information. I understand that a **$25.00 fee** will be added to my account in the event of a returned check due to insufficient funds. I authorize my insurance benefits to be paid directly to Sound Sleep Health. I also authorize the release of any information required by my insurance carrier to process medical claims. If I am prescribed Durable Medical Equipment (DME), such as a CPAP machine, mask and/or tubing, I am aware that I have a choice in companies from which I can receive my equipment.

**SIGNATURE**: ________________________________________ **DATE:**________________

****MEDICARE PATIENTS ONLY****

**Sound Sleep Health bills Medicare directly. You are responsible for your annual deductible, and 20% co-insurance. Most secondary insurances will pick up these fees.**

***I authorize Sound Sleep Health to release to the US Federal Government, or its designated agent, any information needed to process my medical claims. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits be made to my healthcare provider if assignment is accepted.***

**SIGNATURE:** ____________________________ **DATE:** _____