sleeptechnologies

PATIENT REGISTRATION FORM

Today's date:			Appointment time:	
PATIENT INFORMATION				
Patient's last name:	First:	M:	Marital status:	Gender:
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Date of Birth:	
Street address:			SSN:	
City:	State:	Zip:	Phone no.:	
Email address:				
Referring or Primary Care Physician:				
INSURANCE INFORMATION				
Primary insurance:	Policy no.:		Group no.:	
Subscriber's name:			Date of Birth:	
Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other				
Secondary insurance: (if applicable)	Policy no:		Group no.:	
Subscriber's name:			Date of Birth:	
Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑ Other				

I authorize my insurance to be billed and benefits paid directly to Sleep Technologies. I understand that I am financially responsible for any balance that my insurance does not cover. I also authorize Sleep Technologies or insurance company to release any information required to process my claims.

Initial: _____

HIPAA PATIENT CONFIDENTIALITY

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence. In order to protect your privacy please complete the following, which tells us how you wish to be contacted and who, we may discuss your healthcare with.

Full name:	Relationship to patient:	Phone no.:
Full name:	Relationship to patient:	Phone no.:

- ❑ You may leave a message with department/office name and call back on voicemail/ answering machine at home/ cellphone.
- ❑ You may leave a message with medical information on voicemail/ answering machine at my home/ cellphone.
- ❑ You may email me with medical information

Patient Consent for Photograph

I hereby consent to my photograph being taken for medical documentation and irrevocably authorize Sleep Technologies Ltd and those employees acting with its permission to photograph my face for report inclusion. The photograph will be utilized as part of my general sleep therapy medical records and may be transmitted to referring physicians and healthcare personnel as medical information. Any release of medical information, including photos, will be in accordance with the appropriate patient privacy procedures.

Initial: _____

HIPAA Acknowledgement and Consent

The above information is true to the best of my knowledge. By signing this form, I understand that under the Health Insurance Portability and Accountability Act, I have the certain rights to privacy regarding my protected health information. I understand that this information can and will be used to Conduct, plan and direct my treatment and follow up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. I understand I have the right to review Sleep Technologies Privacy Notice before signing this form and I have the right to revoke this consent, in writing sign by me. However, such revocation shall not affect any disclosures we have already made prior to my consent.

_____ _____

Patient/Guardian signature *Date*