GUAM SLEEP CENTER

REGISTRATION

PATIENT INFORMATION

NAME: *LAST* *FIRST* *MIDDLE or MAIDEN*

DOB: MM DD YY | **SS#:** | **SEX:** ☐M ☐F | **MARITAL STATUS:** ☐SINGLE ☐MARRIED ☐OTHER _____

TEL#: (*H*) (*C*) | **E-MAIL:**

RESIDENTIAL ADDRESS: *STREET* *CITY* *STATE* *ZIP*

MAILING ADDRESS: *STREET* *CITY* *STATE* *ZIP*

EMPLOYMENT: ☐F/T ☐P/T ☐S/E ☐U/E ☐STDT ☐RET | **VETERAN:** ☐Y ☐N | **MILITARY GRADE:**

OCCUPATION: | **EMPLOYER:**

TEL#: | **LENGTH OF EMPLOYMENT:**

EMPLOYER ADDRESS: *STREET* *CITY* *STATE* *ZIP*

SPOUSE: | **EMPLOYER:** | **TEL#:**

EMERGENCY CONTACT: | **RELATIONSHIP:**

PHONE: (*H*) (*W*) (*C*) (OTHER)

PRIMARY INSURANCE

CARRIER:	**SUBSCRIBER:**	**DOB:**
RELATION TO PATIENT:	**MEMBER ID#:**	**SS#:**

SECONDARY INSURANCE

☐ Not Applicable

CARRIER:	**SUBSCRIBER:**	**DOB:**
RELATION TO PATIENT:	**MEMBER ID#:**	**SS#:**

RESPONSIBLE PARTY IF OTHER THAN PATIENT

NAME: | **DOB:**

ADDRESS: *STREET* *CITY* *STATE* *ZIP* | **TEL#:**

RESPONSIBLE PARTY SS#: | **RELATION TO PATIENT:**

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT FOR PHYSICIANS' SERVICES

I hereby give consent to **Guam Sleep Center and/or Gabriele M. Barthlen, M.D.** to provide whatever treatment is deemed necessary. I authorize any holder of medical information to release to my insurer and its agents, physicians, hospitals and other medical providers any information needed to determine benefits payable for these services.

I request that payment of authorized Medicare and other insurance benefits be made on my behalf to the physician(s) named above for any services furnished to me or to the patient (if patient is not responsible party). This assignment will remain in effect until revoked in writing.

I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office. If my insurance does not pay all bills submitted, I acknowledge that these bills are my responsibility and will guarantee payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

Signature of Responsible Party _____ Date _____

Relation to Patient if other than self _____

GUAM SLEEP CENTER

535 N. Marine Corps Dr, Ste 1A, Tamuning, GU 96913
Tel: (671) 647-6669 • Fax: (671) 647- 6277 • *www.guamsleepcenter.com*

AASM ACCREDITED Facility Member™

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. **Cancellation, Rescheduling, and No-Show Fees.** Appointments must be canceled or rescheduled more than 48 hours in advance otherwise a fee of $50 will be assessed. You will be charged $100 no-show fee for failing to notify the Sleep Center of inability to keep the appointment. _____
4. **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. _____
5. **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. _____
6. **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. _____
7. **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. _____
8. **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. _____
9. **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. _____
10. **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. _____
11. **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

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CONSENT FOR POLYSOMNOGRAPHY

By signing in the space provided below, I affirm I understand 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. During the study, I will be free to move in bed but must ask for assistance to get out of bed (head box must be disconnected). I will be observed and recorded 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 AUDIO

By signing in the space provided below, I**,** _____hereby authorize the taking of photograph(s)
(*Print name of Patient or Guardian*)

and/or recording of video and/or audio of the patient, _____**,** by Guam Sleep Center or their
(*Print name of Patient*)

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 abovementioned purposes. 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. Use of the video for medical education will not identify you by name.

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, I authorize the doctor and his/her staff to contact me at 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. I also authorize the following communication methods in reference to items that assist the practice in carrying out TPO:

☐ Email***** to my email address: _____ *****I understand Guam Sleep Center does not email medical records.

☐ Text message to my mobile phone number: _____

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.

By signing in the space provided below, I also affirm that I have read the Notice of the Uses and Disclosures of Protected health Information. I was informed that I may obtain a printed copy of the notice from the receptionist. I hereby acknowledge that I viewed a copy of the notice.

_____

Signature (patient or guardian)* Legal Guardian's Name (Print) Date

_____

Relationship to patient (if other than self) Witness's Signature Date