



	Last Name	First Name	M.I.	Birthdate
Patient:				
Spouse:				
Address:				
City:		State:	Zip:	

	Social Security Number	Sex	Home Phone	Work Phone	Work Hours
Patient:					
Spouse:					
Patient's Employer:				Occupation:	
Spouse's Employer:				Occupation:	
Primary Insurance Company Name:					
Name of Primary Insurance Holder:					
Member ID:			Group #:	Effective Date:	
Claims Address: (on card)					
Secondary Insurance Company Name:					
Insured's Name:					
Insured's ID #:			Group #:	Effective Date:	
Claims Address: (on card)					
Referring Physician:					

**EMERGENCY INFORMATION**

Person to notify in case of emergency (other than parents): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**CONSENT TO RELEASE OF INFORMATION**

I authorize my insurance company(ies) to furnish to an agent of Comprehensive Sleep Solutions (CSS) any and all information pertaining to my insurance benefits and status of claims submitted by CSS for services rendered. I further authorize CSS to release to my insurance company(ies) any and all information pertaining to me for benefit determination. This consent will be valid for whatever period of time is necessary for the individual/agency requesting to review my records to fulfill their purpose, or until I revoke this consent in writing. Such a revocation of this consent will have a prospective effect only.

**FINANCIAL AGREEMENT**

I agree that in return for the services provided to the patient, I will pay the account of the patient, and/or prior to the performance of the study make financial arrangements satisfactory to Comprehensive Sleep Solutions for payment.

I hereby authorize and request that payment on any authorized Medicare benefits to be made on my behalf for this sleep study be made directly to Comprehensive Sleep Solutions, LLC.

If any signer is entitled to benefits of any type whatsoever under any policy of insurance insuring patient, or any other party liable to patient, the benefits are hereby assigned to Comprehensive Sleep Solutions, LLC for application on patient's bill. However, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL.

IN RENDERING TREATMENT, COMPREHENSIVE SLEEP SOLUTIONS IS RELYING ON MY AGREEMENT TO PAY THE ACCOUNT.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_