

SLEEP CENTER OF INDIANA

106th & North Meridian
Located at St. Vincent Heart Center of Indiana

Sleep Study Consent Form

Date: _____

I authorize a _____
(procedure type) to be performed on _____
(patient name) under the medical direction of _____.

The nature and purpose of this as well as the risks involved and possible complications have been fully explained to me. No individual with _____ (facility) or the physician's office has given me a guarantee or assurance as to the results that may be attained. I have been informed prior to tonight that the technician performing the study may be of the opposite sex and have agreed to continue with the test.

I understand a photograph will be taken and that video monitoring and recording will be performed as part of the diagnostic test. I hereby give permission to release my medical information that may be deemed necessary as part of this procedure. I also understand and consent to the results of this procedure being released to other physicians as deemed necessary in my continued care.

I do consent to the release of medical records in the process of filing insurance claims. I understand the billing of this procedure will be managed by _____. Any benefits paid on my behalf, will be paid to _____.

I understand that a separate bill will be filed for the interpretation by the interpreting physician.

(Patient)

(Witness)

Date

Date