Milford Regional Physician Group
The Benchmark for Quality Care

Sleep Center: Patient Information

YOU HAVE BEEN SCHEDULED TO PICK UP A HOME SLEEP TEST AT NEUROCARE CENTER FOR SLEEP LOCATED AT:

Milford Regional Sleep Center
194 West Street #10, Milford, MA 01757
Tel: 617-250-8050

When you arrive at the location, please park out front and then go into the building to pick up your device.

INSURANCE
If your insurance requires a pre-certification, and we've received authorization, this does NOT guarantee 100% coverage. Because coverage varies, **check directly with your insurance carrier** regarding your specific plan coverage and any out-of-pocket expenses related to the test.

MEDICATION
Take all regular medications, including sleep aids, as prescribed, unless otherwise directed by your doctor.

IN PREPARATION FOR YOUR STUDY:
Watch an instructional video on device set-up at: www.neurocareinc.com/home-sleep-apnea-testing

Neurocare will call or text you to confirm. Please confirm your appointment via text or phone.

ON THE DAY/NIGHT OF YOUR STUDY:
Follow your normal bedtime schedule and try to sleep for at least seven hours (in any position) if possible. Minimize caffeinated drinks, alcohol, and naps the day of your study.

AFTER YOUR SLEEP STUDY:
- Drop-off the equipment **the day after you pick it up** between **8:30am and 11:00am**
- If you are picking up your device on Friday, it will need to be returned the following Monday between 8:30am and 11:00am (The office is closed on the weekend)
- *Failure to drop off the device at the designated time will cause disruption to other patients scheduled for an appointment*
- You may have someone else drop off the equipment. (The person testing does not need to be present when equipment is returned)

RESULTS OF YOUR STUDY:
You must contact your referring physician for sleep study results. Study results will **not** be sent directly to patients.

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For HIPAA Notice of Privacy Practices, please visit:
https://www.milfordregionalphysicians.org/about/patient-rights

Home Sleep Test Service Agreement

Patient Name *DOB*

1. **Role of your Physician**: I acknowledge and agree that the **SLEEP CENTER** is authorized to perform diagnostic testing only after an order from my physician. The **SLEEP CENTER** is not legally authorized to make medical decisions regarding my treatment which is the responsibility of my physician. The **SLEEP CENTER** Medical Director and clinical staff request that I notify them of any concerns that may arise during my sleep study so that they may discuss the issues with me or my physician.
2. **24 hour availability:** I understand that in addition to the instruction I will receive on how to apply the test device properly, there will also be 24 hour availability of qualified personnel to answer questions or troubleshoot issues with the device. Caution must be taken to ensure that the cables do not encircle the patient's neck. There could be some discomfort associated with the application of the sensors, and in the event of any concerns, I agree to call the **SLEEP CENTER** at the telephone number provided with the device. In case of medical emergency, I should dial 911 for emergency assistance.
3. **Use and Return of Device:** I understand that my test results must be interpreted from the device data so immediate return is important for my diagnosis and so that other patients may have the same opportunity to be tested as I did. I agree to use the testing device on the night that I receive the device and return it the next day. I will handle the device with utmost care.
   - I understand that I am personally liable for the return of the home sleep test device that is being used at my home. I agree that I am responsible for the replacement cost of the HST device, or cost of repairs, if it is stolen, misplaced, or damaged due to abuse or my failure to exercise reasonable care. I agree to use the device only in the manner for which it is intended and not to attempt to make any repairs of any kind. In the event the device becomes inoperable, I will notify the **SLEEP CENTER** at once on the 24 hour phone number included with the device.
   - The **SLEEP CENTER** expects the device to be returned on the agreed return date. Delays in returning the equipment are subject to a late fee of **$50 per** day. If an emergency makes it impossible to return the device on the agreed date, I understand that I must call the **SLEEP CENTER** administrative office at 617-250-8050 to arrange for a suitable alternative return date.
   - If I fail to return the equipment to the **SLEEP CENTER**, I will be, and agree to be, responsible for the full value of the testing device plus the cost of collections (which, collectively, is $2,075) and **MRPG** may be forced to seek legal recourse or pursue legal remedies, including sending me to an independent collection agency to pursue the device replacement fee and collections costs ($2,075). I agree to pay $2,075 (the device replacement fee and reasonable collection costs), plus attorney's fees (if required to ensure the return or replacement of device). The **SLEEP CENTER** remains the owner of the device at all times during the permitted use of the device.
   - *I understand and agree not to return the HST device to any other location, department, person, or health provider, except as instructed.*
4. **Release of Information**: I authorize the **SLEEP CENTER**, the physician who interprets the sleep study, and any other holder of medical or other information relevant to my care and testing to release information requested for billing and payment purposes, and to a medical provider for treatment purposes (including interpretation of my sleep study). I also authorize the release of my medical records to any regulatory or accreditation organization, and for healthcare operations as permitted under the Health Insurance Portability and Accountability Act (HIPAA).
5. **Assignment of Benefits:** I agree and understand that I am financially responsible for any services not covered, not allowed, or not paid due to the terms of my insurance coverage. I understand that all co-payments, deductibles, and non-covered charges are due at the time of service and accept full responsibility for payment of services and/or for securing necessary primary care referrals and prior-approval for medical services. I understand that if my insurance coverage changes to a non-contracted plan or is cancelled/retroactively cancelled I am responsible for services rendered.

   I fully understand that I am financially responsible for any tests or services ordered by my provider that are not covered by insurance.

   I agree to promptly reply to inquiries related to insurance questions or payment methods.

I have read and understand the contract above, and agree to the provisions.

Patient Signature____ Date ___________________

Or, Personal Representative:___________________________________Date_____________Relationship_________________________