NW REST

ApneaTrak Home Sleep Test

365 Warner Milne Rd. Suite 209 | Oregon City, OR 97045

Phone: (503) 495-6200 | Fax: (503) 495-6208

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Please review and initial each of the following statements:

1. I have received face-to-face demonstration of the ApneaTrak Home Sleep Test Equipment application and understand the steps to follow when putting on the sleep monitoring equipment.

   _____
   (Initials)

2. I agree to return the ApneaTrak Home Sleep Test equipment to NW Rest by the following date: _____

   _____
   (Initials)

3. Failure to contact NW Rest or return the equipment by the above agreed upon date will result in a daily charge of $100.00 (one hundred dollars) per day until the sleep equipment is returned to the office in proper working condition.

   _____
   (Initials)

My signature below is to certify that I, the undersigned, hereby consent to and authorize the administration of all procedures and/or treatments of sleep diagnostics. I also furthermore authorize all medical personnel to provide Northwest Rest, LLC any medical information/history required for third party billing purposes. I also acknowledge that my medical information will be kept confidential and will not be released without my consent. I also authorize my insurance company to send all payments directly to Northwest Rest, LLC.

_____

Patient Signature Date

For Office Use Only

Device Serial Number: _____

Date Checked Out: _____ Date Due Back: _____