HST UNIT POLICY

Insurance Information:
Patients are required to provide accurate insurance information and notify our office of any changes with insurance, address, and phone numbers. If there's a change to your insurance and we are not notified prior to that change or do not accept the new insurance, you may be responsible for payment in full.

Co-payments:
Co-pays are due before an HST (home sleep apnea testing unit) is dispensed to you. You're responsible for knowing your coinsurance, deductible, benefits and coverage.

HST Policy for Pick Up and Mailing:
Getting your HST:

- Mailed: Sleep Insights will mail the HST directly to your house. It must be your physical address and not a PO Box.
- Picked up: You will pick up the HST at your local Sleep Insights location and return the HST to that same location.

Before we will mail you the HST or before you can pick it up:

- You must have paid your co-payment in full or have agreed to a payment plan.
- All necessary paperwork/agreements must be filled out and signed.

Returning the HST:

- Mailed: If the HST was mailed to you, you must send the unit back within 72 hours of receipt.
  Please make sure all HST parts are placed into the case before return shipping. Refer to the Return Chart below for shipping timeframes.
- Picked up: If picked up at one of our locations, the HST must be returned to Sleep Insights within 24 hours.

If additional time is needed with the HST, it must be approved by a member of the Sleep Insights staff. Please contact us so we can work with you on a new timeframe.

SHIPPING RETURN CHART

If you received the HST in the mail on:	**You need to place the HST in mail no later than:**
Monday	Thursday
Tuesday	Friday
Wednesday	Saturday
Thursday	Monday
Friday	Monday
Saturday	Tuesday

HST PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

PATIENT FINANCIAL RESPONSIBILITIES

Before we will mail you the HST or before you (or patient's guardian, if a minor) can pick it up:

- You must have paid your co-payment in full or have agreed to a payment plan.
- All necessary paperwork/agreements must be filled out and signed.

You may incur and are responsible for paying a $40 fee for all returned checks.

If you have a deductible plan that has not been met yet you will be responsible for the full allowed amount until it is met. Any overpayments will be applied to any following appointments or refunded in full.

If picked up at one of our locations, the HST must be returned to Sleep Insights within 24 hours. If the HST was mailed to you, you must send the unit back within 72 hours of receipt.

A $50 charge will be added to your bill for every day you are late returning your HST device. If the HST has not been returned to Sleep Insights within 30 days of the date it was dispensed, Sleep Insights will consider the device stolen and you will be billed for the total cost of the HST unit.

INSURANCE

The following are the patient's responsibility:

- Know your coinsurance, deductibles, benefits and coverage.
- Notify our office of any changes to insurance/address/phone numbers.
  - *If there is a change in insurance and we are not notified prior to the change or we do not accept the new insurance, you may be responsible for payment in full.*
- Pay for any allowed amounts not covered by insurance

I have read, understand and agree to the provisions of this HST Patient Financial Responsibility Agreement. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Sleep Insights Medical Associates, PLLC reserves the right to change or amend this statement at any time and at its discretion.

X

Signature of Patient/Responsible Party Print

HST UNIT LOAN AGREEMENT

This home sleep apnea testing unit (HST) has been provided to you by Sleep Insights Medical Associates, PLLC for an overnight test. If you are picking up the HST from a Sleep Insights location, the HST must be returned to Sleep Insights within 24 hours from when you picked it up**.** If the device was mailed to you, it must be mailed back within 72 hours of receipt.

A $50 charge will be added to your bill for every day you are late returning your HST device. If the HST has not been returned to Sleep Insights within 30 days of the date it was dispensed, Sleep Insights will consider the device stolen and you will be billed for the total cost of the HST unit.

If additional time is needed with the HST, it must be approved by a member of the Sleep Insights staff.

I, _____, have read the above agreement and will adhere to it. I understand that it is my responsibility to return the HST in a timely fashion, in proper working order.

_____ _____

Patient Signature Company Representative

Please initial to indicate you have received written instructions for the HST: _____

_____: Home sleep testing Identification

_____: Date Out

_____: Expected Return Date

LOCATIONS

Rochester	755 Jefferson Road, Suite 110, Rochester 14623	**p (585) 385.6070**
Batavia	47A Batavia City Centre, Batavia, NY 14020	**p (585) 219.4330**
Geneseo	50 South St**,** Geneseo, NY 14454	**p (585) 335.4285**
Dansville	Noyes Memorial Hospital, 111 Clara Barton St, Dansville, NY 14437	**p (585) 335.4285**
Springville	224 East Main Street, Springville, NY 14141	**p (716) 379.8538**
Olean	2676 West State Street, Suite 700A, Olean, NY 14760	**p (716) 379.8538**
Orchard Park	3775 Southwestern Blvd, Suite B, Orchard Park, NY 14127	**p (716) 272.1444**
North Buffalo	2625 Delaware Ave, Buffalo, NY 14216	**p (716) 403.2005**
Niagara Falls	7220 Porter Rd, Niagara Falls, NY 14304	**p (716) 575.0075**

sleep insights HST

HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). Sleep Insights Medical Associates, PLLC (SIMA) Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

SIMA needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below.

_____ _____

Print Patient Name (and Guardian name if applicable) **Patient Date of Birth**

I give my consent for SIMA to use and disclose my PHI to carry out TPO. With this consent, SIMA may mail items or call my home (or other alternate locations) to facilitate TPO and may leave messages regarding healthcare information and any matter associated with my account (e.g. appointment reminders, test results, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

___ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to SIMA to also specifically speak with:

___ spouse: _____

___ relative: _____

___ DOT or employer-directed physician: _____

___ other: _____

SIMA may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

_____

_____

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

_____ _____

Signature of Patient **Date**