PACIFIC SLEEP
PROGRAM

2120 Exchange St, Ste 302
Astoria, OR 97103
Phone: (503) 325-3126
Fax: (503) 325-4933

You have been scheduled for a:

☐ Home Sleep Study (HST) on: _____

Please **arrive** to the office by _____**AM/PM** for your HST set up. A technologist/ Medical Assistant will be awaiting your arrival.

During this appointment we will be instructing you on the proper technique on how to set up the home sleep study device. **You will also be given a brief questionnaire to complete the night before your scheduled study as well as the following morning. The device will need to be returned to Pacific Sleep Program by 12:00 noon the following day, unless otherwise directed.**

You will be called 7 days prior to confirm your sleep study. If you do not confirm within 1 business day prior to the scheduled sleep study, the sleep study will be cancelled.

If your appointment is on Friday, Saturday, or Sunday and you need to cancel, please call by noon the Thursday prior to your appointment. **A fee of $75.00 will be charged directly to you for a late cancellation or a no-show appointment.**

Insurance: Please contact your insurance representative to determine your coverage. Your carrier will be billed for your appointments; however, any charges not covered or remaining balances will be your financial responsibility. Authorizations will be processed by our office before your scheduled sleep study. Inform your insurance carrier that you will be taking an unattended home sleep study.

Your follow up appointment has been scheduled:

DATE: _____

TIME: _____

PROVIDER: _____

☐ In-office visit

☐ Telehealth visit