PACIFIC SLEEP
PROGRAM

CONDITIONS OF REGISTRATION

Medical Consent:

- I consent to the provision of health care services at Pacific Sleep Program and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, and medical treatment. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- I acknowledge that the health care provider(s) treating me may be independent contractors, not employed by Pacific Sleep Program.
- I understand if special procedures or operations are needed, my health care provider will discuss this with me, and my additional consent will be required.
- I understand that some clinics are teaching institutions and I consent to residents and students being involved with my care. I understand these caregivers are always under the supervision of qualified health care instructors. I understand that I will be informed whenever possible of the resident or student status of specific caregivers.

COVID-19:

- **The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which Pacific Sleep Program adheres to comply.**
- I understand that it is my obligation to protect the staff and other patients from any exposure to the COVID-19 virus as much as possible. As such, I understand that I am required to wear a mask upon entering the clinic and required to wear a mask during the time that I am physically in any portion of the Pacific Sleep Program facilities unless asked by a medical professional to remove the mask for examination or testing purposes. I understand that if I refuse to wear a mask, I will be asked to leave the facility.

- I understand that if I have cough, fever, shortness of breath or other symptoms which may be secondary to the COVID-19 virus, have a family member or close contact with COVID-19, travel to an area of high COVID-19 prevalence or am diagnosed with COVID-19, it is my responsibility to inform the clinic as soon as possible if I plan to attend an in-person visit or perform an in-lab sleep study.

- I understand while Pacific Sleep Program follows state, federal and regulatory rules for masking, cleaning, and distancing to minimize any risk of transmission of COVID-19, Pacific Sleep Program cannot guarantee that I am not exposed to the virus during my physical presence in their facilities. As such, I hereby agree to indemnify and hold harmless and do hereby release Pacific Sleep Program from any claims, actions or causes of action for any personal injury as a result of COVID-19 infection.

Telemedicine services:

I hereby consent to using live telemedicine services provided by Pacific Sleep Program. I understand that telemedicine services are conducted through an interactive audio and video connection which allows my provider to consult with me about my medical condition. I understand that these services may involve the communication of my health information, both orally and visually, to my provider.

I further understand the following with respect to Pacific Sleep Program's telemedicine services:

- No data or health information will be recorded, stored, or archived from the audio/video portion of these services.

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

- I understand that the information disclosed to me during my telemedicine session is except as per mandatory and permissive exceptions to confidentiality in the State of Oregon.

- Risks and consequences from use of these services may include but are not limited to, the possibility that the transmission of my health information could be intercepted or accessed by unauthorized persons and the inability to perform a physical exam through telemedicine.

General Consent for sleep studies and PAP (positive airway pressure) application:

For sleep studies, (either at home or in lab) and PAP application, the most likely and most serious risks of the procedure include, but are not limited to:

- Contact dermatitis
- Adverse reactions to adhesives
- Aerophagia
- Eustachian tube dysfunction
- Pneumothorax
- Anaphylactic reactions (rare)

I am aware that there may be other risks or complications not discussed that may occur. I also understand that during the course of the proposed procedure, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure.

Sleep testing and the use of sedative-hypnotics:

If I take a sleep aid before or during a sleep study, I am aware that sedatives such as diphenhydramine (Benadryl), doxylamine (Unisom), trazodone, Ambien (zolpidem), Sonata (zaleplon) and other sleep aids may impair my thinking and reaction time. I understand that I may feel drowsy in the morning after taking a sleep aid.

I understand that Pacific Sleep Program strongly recommends that I wait at least 7 hours or until I am fully awake before I do any type of activity that requires me to be awake and alert. If I am unable to safely operate a motor vehicle, I understand that I must have a ride home available in the morning or, if day staffing is available the next day, I will remain in the clinic until I am able to safely operate a motor vehicle or will contact someone to drive me home.

If I decide to terminate my study, I acknowledge that I am refusing at my own insistence and without the authority of and against the advice of the facility, requesting to leave against medical advice and I hereby release Pacific Sleep Program from any responsibility for all consequences which may result from the use of a sleep aid during the study or from leaving against medical advice.

Prescription Policy:

Please contact your pharmacy for prescription refills. Medication refill request may take up to 5-7 business days to process. Prescriptions will be handled Monday through Thursday, 8:00 AM-4:30 PM. There will be no refills after hours or on the weekends so please plan accordingly.

Pacific Sleep Program will only authorize refills on medications prescribed by Pacific Sleep Program providers. Medications prescribed by other providers will not be refilled by Pacific Sleep Program.

Pacific Sleep Program will notify you if the prescription has been denied or there is a need for a follow up visit prior to refilling your medication. Keep in mind that controlled substances require signed prescriptions by law and cannot be refilled without an office visit.

Financial Agreement:

As a courtesy to you, our office will bill your insurance company on your behalf for services rendered, provided complete and accurate information is provided at the time of each visit.

- I understand full payment is required at the time of service for all co-payments, deductibles, and services or products not covered by or not billable to my insurance company.

- I understand I am responsible if insurance payment is not received after 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing.

- I understand I will be charged a fee of **$75.00 for a missed provider appointment, whether the appointment is conducted in the office for virtually** or if I cancel my appointment in less than 1 business day of the scheduled appointment.

- I understand I will be charged a fee of **$250.00 for a missed sleep study appointment** or if I cancel in less than 1 business day of the scheduled sleep lab appointment.

- I understand all late cancellation fees and missed appointment fees are **NOT** payable by my insurance company and will be billed directly to me.

- **I understand if I have 2 late cancellations or no-shows of office appointments or 1 late cancellation/no-show of a sleep study, I may be discharged from the practice.**

- I understand I will be charged a **$35.00 service charge on all returned checks.**
- I understand if my account is directed to a collection agency for non-payment of services, I may be discharged from the practice.
- I understand if my insurance requires me to have a referral for services provided by Pacific Sleep Program, it is my responsibility to obtain the referral.
- I understand that if my insurance changes, I am responsible for notifying Pacific Sleep Program immediately prior to any further visits, sleep testing or DME dispensing and that if I do not, I am fully responsible for any charges which may not be covered by my insurance.

Financial Certification:

I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

By signing below, I (Patient or Authorized Consenter) hereby acknowledge I have read and fully understand the above information. I have asked questions about anything not clear to me and am satisfied with the answers I have received. I understand that I may revoke my consent or authorization at any time except to the extent that action has been taken in reliance on such consent or authorization.

_____	_____	_____
Patient or Legal Representative	Relationship	Date