Falcon Sleep Center

Authorization and Release Form

Consent to Perform Procedure

I, _____ authorize Falcon Medical Group, Inc. to perform Polysomnographic (sleep study) procedures. These procedures will be used for diagnostic, therapeutic or research purposes.

Long term EEG monitoring and Polysomnographic procedures are non-invasive multi channel recordings designed to record diagnostic physiologic parameters for neurological or sleep disorders. Monitoring leads are attached with tape or snap electrodes and medical crème. Minor skin irritation associated with the cleaning of the application sites and tape may be a side effect of the procedure.

When Continuous Positive Airway Pressure (CPAP), Bi-level PAP or oxygen is indicated by policy during a sleep study, it may be applied to improve cardiac or respiratory events occurring during sleep. Common complications of CPAP and Bi-level is dry mouth; burning sensation in the nose, and skin irritation. With any procedure, there may be unforeseen or unexpected side effects experienced. Notify the technologist of any discomfort you experience during your procedure. I understand there is a possibility of reactions associated with tape.

Insurance Assignment & Release

I authorize my Insurance Benefits to be paid directly to Falcon Medical Group, Inc. I also authorize the facility to release any information required and/or requested by my insurance carrier.

I understand that I am responsible for insurance deductibles, co-pays and percentages as per my insurance policy. I understand all fees are due at the time services are rendered. I understand that there is a $75 charge for confirmed appointments cancelled without 24 hours prior notice or failure to show up for a scheduled and confirmed appointment.

I also understand that Falcon Medical Group, Inc files claims to the insurance company as a courtesy, and that I am responsible for any services the insurance company does not pay for.

Consent to Video/Audio Recording

I hereby authorize Falcon Medical Group, Inc., its employees or agents, to digitally video and/or audio record me while under the care of the sleep center. I further authorize the use of any such photographs, video, and audio recordings be used by other physicians involved in my medical care.

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical purposes, to assist in evaluating my sleep, or in the event of legal action. The sleep center and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings. Any recordings obtained during the course of the sleep study will remain confidential, and will be considered a protected portion of your medical record.

Patient Signature	Date	Witness	Date