DEARBORN SLEEP LAB
Division of Millennium Medical Group South, P.C.
CONSENT FOR POLYSOMNOGRAPHY
AUTHORIZATION TO BILL

Details
A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

- Brain waves
- Heart rate
- Breathing rate
- Oxygen level
- Eye movements
- Chin movement
- Leg movements

The study also may involve other sensors. The sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you.

Risks
There is no major health risk involved with this sleep study.

Agreement
My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technician will attach sensors to my body for the study.
3. The removal of the sensors in the morning may irritate my skin and cause redness.
4. A video camera will record me as I sleep. A technician will watch me on a monitor in the control room.
5. I will be free to roll over and move in bed during the study.
6. I will need to ask for help if I must get out of bed for any reason.
7. The technician may need to enter the room to wake me if there is a problem.
8. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
9. I understand why I am taking this sleep study.
10. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.

Authorization to Bill
I authorize my insurance benefits to be paid directly to the Dearborn Sleep Lab (DSL). I understand that I am financially responsible for any balance. I also authorize DSL or my insurance company to release any information required to process my claim.

I also acknowledge that if I fail to cancel or reschedule a scheduled appointment no less than 24 hours before the test, I will be subject to a $100 no show fee. I understand that I will personally be responsible for this fee, not my insurance.

______________________________________ ______________
Signature (Patient or Guardian) **Date**

______________________________________ ______________
Signature (Witness) **Date**