MDS

Medical Diagnostic Solutions
Sleep Testing and Interpretation Services

954-401-7505 Tel
877-611-6844 Fax

PATIENT INTAKE FORM
Please fill out all of the information and sign the form

First Name _____ MI ____
Last Name _____
HOME or BILLING ADDRESS
Street _____
City _____**State** ___ **Zip Code** _____
SHIPPING ADDRESS
Street _____
City _____**State** ___ **Zip Code** _____
PHONE
Home ( ) _____ - _____
Cell ( ) _____ - _____
Work ( ) _____ - _____ **Ext** _____
Email _____ @_____ . _____
Sex ☐M ☐F **SSN** (Last 4 #) _____
Age ___ **Birth Date** ___ - ___ - _____
Height __ feet ___ inches **Weight** _____ pounds
ORDERING DOCTOR
First _____ MI ___
Last _____
Phone ( ) _____ - _____ **Ext** _____
Fax ( ) _____ - _____
PRIMARY DOCTOR (if different)
First _____ MI ___
Last _____
Phone ( ) _____ - _____ **Ext** _____
Fax ( ) _____ - _____
PAYER ☐Self ☐Insurance ☐Employer ☐Other
INSURANCE ☐HMO ☐PPO ☐Medicare ☐Other
Company 1 _____
Phone ( ) _____ - _____
Member _____
Relationship to patient ☐Self ☐_____
ID # _____Group # _____
Company 2 _____
Phone ( ) _____ - _____
Member _____
Relationship to patient ☐Self ☐_____
ID # _____Group # _____
REFERRED BY _____
Phone ( ) _____ - _____

EMPLOYER _____
Contact _____
Phone ( ) _____ - _____ **Ext** _____
CDL# _____ **State** ___

Financial Agreement

Medical Diagnostic Solutions, LLC (MDS) does not guarantee that the Home Sleep Test (HST), its interpretation, or any recommended equipment, additional medical testing and/or treatment, based on the results of the HST or overnight oximetry testing, CPAP equipment, related supplies, and CPAP compliance monitoring or reporting (collectively or individually referred to as "Services") will be reimbursed in full or in part by any third party payer. MDS uses third party vendors to perform the Services. These vendors will bill you and/or your health insurance company as applicable. I authorize these vendors to bill my insurance carrier on my behalf. However, I understand that I am financially responsible for all payments, co-payments and deductibles due on all Services. I understand that I am financially liable for damage to or loss of the HST and/or Oximetry equipment if due to my negligence.

Privacy and Authorization to release medical records

I authorize MDS or any of its vendors to release the results of my home sleep test and any other applicable private or protected health information to the physician that ordered the HST or other Services, to any vendors who provided Services to or for me, to any of my treating physicians or other healthcare professionals, and to any third party payer if requested. I specifically authorize my HST results to be forwarded to any home medical equipment (HME/DME) provider in order to receive the appropriate equipment and supplies ordered by my treating physician based on my sleep test results. I acknowledge that I have received or have been given the opportunity to obtain the MDS **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION** by calling MDS or reviewing it on the MDS Website www.MDSsleep.com

Signature _____ Print Name _____ Date _____ **FAX TO: 877-611-6844**

☐ Patient or ☐ Personal Representative* ☐Legal Guardian ☐Healthcare Power of Attorney ☐Relative ☐ Other

*Personal Representative to sign only if patient is physically or mentally unable to sign