EVERYTHING SLEEP IDAHO

CONFIDENTIAL COMMUNICATION REQUESTS

I give permission for EVERYTHING SLEEP IDAHO to provide any information about my medical condition, medical needs, medications, or the status of my account to the following individual(s).

Name: _____ Phone:_____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ *Patient declines releasing any information to a designated person*

From time to time, it is necessary to contact you by telephone for test results or other information. If our patients are not available when we attempt to contact therefore, we would like to leave a detailed voice message. To protect your privacy, we need your permission to leave detailed phone messages on your phone.

Please choose one of the following:
☐ ***I DO CONSENT*** *for EVERYTHING SLEEP IDAHO to leave detailed messages on the following number: _____*
☐ ***I DO NOT CONSENT*** *to have detailed messages left on my phone.*

***THIS RELEASE WILL BE IN EFFECT UNTIL REVOKED OR UPDATED BY THE PATIENT. FOR MINORS, THEY WILL BE ASKED TO COMPLETE ONCE THEY TURN 18 YEARS OF AGE. ***

_____ _____
Signature of Patient or Legal Guardian ***Date Signed***

Assignment of Benefits: *I hereby assign all applicable insurance benefits and direct that payment be made directly to EVERYTHING SLEEP IDAHO, PLLC for all services provided during my visit.*
Release of Information: *I authorize EVERYTHING SLEEP IDAHO, PLLC to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care.*
Financial Responsibility: *I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collection's agency. I understand that if my account is transferred to a collection's agency, any discounts I may have received by EVERYTHING SLEEP IDAHO, PLLC (excluding insurance contract) can be reversed.*
Statements/Messaging: *I understand and agree that, by default, EVERYTHING SLEEP IDAHO, PLLC utilizes electronic means to communicate with patients, including but not limited to financial statements, requests for payment, appointment reminders, etc. I must let EVERYTHING SLEEP IDAHO, PLLC know if I would like to opt out of this type of communication.*
Appointments: *I understand that if I do not notify EVERYTHING SLEEP IDAHO, PLLC of a cancellation of my appointment at least 24 hours prior to the scheduled appointment. On my second occurrence, I may be assessed a fee and/or dismissed from the practice for multiple occurrences.*
Treatment Authorization: *I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at EVERYTHING SLEEP IDAHO, PLLC. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of the patient's care or treatment. I authorize a copy of this document to be used in lieu of the original.*
Liability: *I understand that EVERYTHING SLEEP IDAHO, PLLC is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by EVERYTHING SLEEP IDAHO, PLLC may be involved in my care and treatment, including but not limited to other practitioners, laboratories, diagnostic test facilities, contractors, vendors, product technicians, etc. I understand that EVERYTHING SLEEP IDAHO, PLLC is not liable for the acts or omissions of non-employees or employees acting outside the course and scope of their duties.*
Receipt of Privacy Practices: *I have been offered and/or provided with a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state regulations. I acknowledge the receipt of EVERYTHING SLEEP IDAHO, PLLC Notice of Privacy Practices.*

_____ _____
Signature of Patient or Legal Guardian ***Date Signed***