BRIGHAM AND WOMEN'S Faulkner Hospital

SLEEP CENTER – PATIENT INFORMATION

YOU HAVE BEEN SCHEDULED TO PICK UP A HOME SLEEP TEST AT BRIGHAM & WOMEN'S FAULKNER HOSPITAL LOCATED AT:

1153 Centre St, Suite 5M
Boston, MA 02130
617-796-7766

INSURANCE

Check directly with your insurance carrier regarding any out of pocket expenses related to your test. Your insurance may not pay for 100% of your sleep study. Even if we have obtained precertification, or if the sleep study is determined to be "authorized" or "covered", you may still be responsible for paying your co-pay, any non-covered portions, and any deductible as determined by your insurance.

MEDICATION

Take all regular medications, including sleep aids, as prescribed, unless otherwise directed by your doctor.

IN PREPARATION FOR YOUR STUDY:

Watch an instructional video on device set-up at: https://www.neurocareinc.com/home-sleep-testing

Confirm your appointment via text or phone.

ON THE DAY/NIGHT OF YOUR STUDY:

Follow your normal bedtime schedule and try to sleep for at least seven hours (in any position) if possible.

Minimize caffeinated drinks, alcohol, and naps.

AFTER YOUR SLEEP STUDY:

The day after you pick it up, **return the equipment 7am-11am.**

You may have someone else drop off the equipment (The person testing does not need to be present when equipment is returned).

A Drop Box for your equipment is located: Outside room 5M, to the left of the elevator.

You must contact your referring physician for sleep study results. Study results will not be sent directly to patients.

SLEEP CENTER LOCATION

Enter driveway & go straight to **PATIENT PARKING.** Go through **EMERGENCY ROOM** entrance. Once inside lobby, turn *left* & go through double doors. Turn *right* following signs to **SURGERY CENTER** & pass **PRE-OPERATIVE EVALUATION CENTER** on your *left*. Go to end of hallway to **HILLSIDE ELEVATORS** on the *right*. Take elevator to **5th floor**, exit *right*, and turn *left* at hallway to **SLEEP TESTING CENTER: 5M.**

NAVIGATING BWFH

Directions to the facility once inside are here (Link below):
https://maps.brighamandwomensfaulkner.org/index.html#home

For HIPAA Notice of Privacy Practices, please visit:
www.neurocareinc.com

NeuroCare
CENTER FOR SLEEP

Home Sleep Test Service Agreement

*Patient Name*_____ *DOB* _____

1. **Role of your Physician**: I acknowledge and agree that Neurocare Center for Sleep is authorized to perform diagnostic testing only after an order from my physician. Neurocare is not legally authorized to make medical decisions regarding my treatment which is the responsibility of my physician. Neurocare's Medical Director and clinical staff request that I notify them of any concerns that may arise during my sleep study so that they may discuss the issues with me or my physician.

2. **Technical Support availability**: I understand that in addition to the instruction I will receive on how to apply the test device properly, there will an on call number provided with a registered technologist to answer questions or troubleshoot issues during testing with the home testing device. Caution must be taken to ensure that the cables do not encircle the patient's neck. There could be some discomfort associated with the application of the sensors, and in the event of any concerns, I agree to call Neurocare at the telephone number provided with the device. In case of medical emergency, I should dial 911 for emergency assistance.

3. **Use and Return of Device:** I understand that my test results must be interpreted from the device data so immediate return is important for my diagnosis and for testing other patients. I agree to use the testing device on the night that I receive the device, and I will handle the device with utmost care.

    - I understand that I am personally liable for the return of the home sleep test device that is being used at my home. I agree that I am responsible for the replacement cost of the HST device, or cost of repairs, if it is stolen, misplaced, or damaged due to abuse or failure to exercise reasonable care. I agree to use the device only in the manner for which it is intended and not to attempt to make any repairs of any kind. In the event the device becomes inoperable, I will notify Neurocare at once on the 24 hour phone number included with thedevice.
    - Neurocare expects the device to be returned on the agreed return date. If an emergency makes it impossible to return the device on the agreed date, I understand that I must call the Neurocare administrative office at 617-796-7766 to arrange for a suitable alternative return date. If I fail to return the equipment to Neurocare after 10 days, Neurocare may be forced to seek legal recourse, and I agree to pay reasonable collection costs, including attorney's fees, if required to ensure the return or replacement of device. Neurocare remains the owner of the device at all times during the permitted use of the device.
    - I agree, and understand, that if I fail to return the device to Neurocare on the agreed return date, I will be responsible for the full value of the testing device, which is $1,250. I also understand that if I fail to return the equipment, Neurocare may elect to pursue legal remedies, including sending me to collections to pursue collections costs and the $1,250 device replacement fee.
    - *I understand and agree not to return the HST device to any other location, department, person, or health provider, except as instructed.*

4. **Release of Information**: I authorize Neurocare, the physician who interprets the sleep study, and any other holder of medical or other information relevant to my care and testing to release information requested for billing and payment purposes, and to a medical provider for treatment purposes (including interpretation of my sleep study). I also authorize the release of my medical records to any regulatory or accreditation organization, and for healthcare operations as permitted under the Health Insurance Portability and AccountabilityAct (HIPAA).

5. **Assignment of Benefits**: I assign to Neurocare all insurance benefits and payments to which I am entitled from whatever source, including the Centers for Medicare and Medicaid Services, if applicable, for any services. I authorize Neurocare to seek such benefits and payments on my behalf and to receive the payments. I understand that Neurocare or its agent will bill insurer(s) directly and that my assignment of benefits is ongoing and continuous unless and until I cancel it in writing to the insurer(s) providing my coverage. I will send a copy of any request for cancellation to Neurocare. I understand that I will be responsible to pay all charges, co-payments or deductibles that are not covered by my insurance company, Medicare, or other payment program. I certify that information given by me to Neurocare relating to payment from insurance companies or from Medicare iscorrect.

6. **Location of device delivery**: If I receive instructions and device at a location other than a Neurocare sleep lab (for example at a hospital), it is understood that Neurocare is the test supplier, and the drop off location (for example, a hospital) is not involved in the home sleep test. All inquiries must be directed to Neurocare. Patient choice is available in the selection of the home sleep test provider in which event, in advance of the study, patient's physician should be consulted.

I have read and understand the contract above, and agree to the provisions.

Patient Signature_____ Date _____

Or, Personal Representative:_____ Date_____ Relationship_____