Consent Form

Consent for Use and Disclosure for Protected Health Information

I understand that as part of my healthcare, FusionSleep originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment (my protected health information or "PHI"). I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and therapy information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided,
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I authorize FusionSleep to release my PHI (including copies of records) needed for my treatment, for payment of the services provided to me, and for health care operations such as quality assurance review or the provision of care after discharge. In the event that, as part of my diagnostic care plan, I have a sleep study in a FusionSleep Center, my photograph may be taken. Fusion Sleep may also record integrated data/video monitoring of my sleep test for medical diagnostic and documentation purposes. These images and recordings are an integral part of my sleep test and will be kept as part of my medical record. Fusion Sleep will only release such images and recordings as part of my PHI pursuant to my consent provided here or in accordance with other appropriate procedures for release of medical information. I have the right to review Fusion Sleep's Notice of Privacy Practices prior to signing this consent. FusionSleep reserves the right to revise the Notice of Privacy Practices as well as the Patient Rights and Responsibilities pamphlet at any time. A revised Notice of Privacy Practices may be obtained by visiting the Privacy & Security link on the FusionSleep website or by forwarding a written request. This consent may be revoked at any time in writing by sending a written notice of revocation. All correspondences should be sent to the address below.

FusionSleep – Medical Records
4245 Johns Creek Parkway, Suite A
Suwanee, GA 30024

Consent for Medical Treatment

I am asking for and consent to the delivery of the care by FusionSleep, including all necessary diagnostic tests, examinations and medical treatments as the clinician prescribes. No one has given me a promise or guarantee about how these examinations and treatments will affect me or my condition. I understand that I have the right to see a physician, if I so choose, prior to any prescription drug or device order being carried out by a physician assistant.

Consent to Payment

Payments for services provided are due at the time services are rendered. We accept payments in the forms of cash, check, debit, and the following credit cards: Visa®, MasterCard®, American Express® and Discover®. A receipt of your payment will be provided to you.
As a courtesy, Fusion Sleep may file insurance claims with my insurance carrier. If so, my insurance company may pay FusionSleep any benefits for services rendered. I understand that I am responsible for making available complete and accurate insurance information to file claims. I am aware that some services provided will be billed separately from the office visit and may require a separate co-pay or be applied to my co-insurance/deductible. I understand it is my responsibility to know and understand my medical coverage. I understand that there are some services/items my insurance company may not cover and that my healthcare provider thinks I would benefit from these services/items. I understand that if my insurance company does not cover part or all of these services/items that I am fully responsible for any remainder or all of the payment. I also understand that I can refuse services/items to be filed to my insurance company but that I will be responsible at the time of service to pay for these services/items. For Medicare or Medicaid, I hereby assign to FusionSleep or its affiliate payment of benefits due to me under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act for services provided by FusionSleep or its affiliates, including physician services. I certify that the information given by me in applying for payment under Medicare or Medicaid is correct. I authorize any holder of medical or other information about me to release to Medicare, Medicaid, and their respective agents any information needed to determine these benefits or benefits for related services. In the event that you fail to make payments for services rendered, your account may be turned over to a collection agency. You will be responsible to pay any collection agency fees incurred in the collection of any outstanding balance.

Cancellation and No Show Policy

If I arrive past my scheduled appointment time, FusionSleep will do its best to fit me into the same day schedule but may need to reschedule my appointment for another day. If I need to reschedule a clinic appointment, I will provide more than 24 hours' notice. If I need to reschedule a sleep test appointment, I will call more than 48 hours prior to the scheduled appointment (or by Thursday if appointment is scheduled on the weekend), as insurance authorization is in many cases bound to the date scheduled and may need to be requested again for a different date. If I miss an appointment altogether without contacting FusionSleep prior to the appointment, I may incur fees.The fee for missed clinic appointments is $25.00 for the first "no show" and $50.00 for subsequent "no show" appointments. The fee for a missed sleep test appointment is $150.

Personal Valuables

FusionSleep takes all reasonable precautions to protect any patient property within the FusionSleep facilities, but cannot be held liable for any valuables lost or damaged. I accept full responsibility for any valuables that I bring into the FusionSleep facilities.

Authorization for Electronic Correspondence

I authorize electronic and phone correspondence (including email, SMS and robocalls) with FusionSleep personnel regarding my medical care, scheduling appointments, appointment reminders, collections and other treatment related correspondence which constitutes protected health information (PHI). I have been advised that transmission security and email encryption cannot be guaranteed. I understand and accept the risk to my protected health information by corresponding with FusionSleep electronically. I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to FusionSleep receiving a written notice of withdrawal. I hereby release FusionSleep and its officers, directors, agents and employees from any and all liabilities, responsibilities, damages, losses and claims which might arise from the release of the information authorized.

Medication and Discharge Policy

I have been made aware and given the opportunity to obtain a copy of the FusionSleep Medication policy. I understand that the following are some causes for immediate dismissal from FusionSleep:

- Obtaining a controlled substance medication from any other medical office, hospital, or urgent care while under our care without notifying FusionSleep.
- Altering or forging of a prescription which is a felony and will be reported.
- Lack of effort to comply with treatment
- Disrespectful or inappropriate behavior

GA Code 16-13-43: “...and anyone violating this code will be guilty of a felony, and if convicted, can be imprisoned for up to 8 years and/or fined up to $50,000.”

I understand that in the event that I refuse to sign this consent, FusionSleep may decline to provide services.

Patient Name:

_____

I am the:

Patient

Parent/ Legal Representative

Signature:

_____