Advanced Diagnostic Solutions, Inc.
Fast! Efficient!! Courteous!!

Assignment of Benefits (AOB) & Medical Release

Phone: (352) 293-2810 | Fax: (727) 264-2117

Patient Information

Patient Name: _____ DOB: _____ Gender: Female

Address: _____ Phone: _____

City/State/Zip: _____ Cell: _____

Primary Insurance: _____ ID#: _____

***Medicaid may not cover this test** and the patient will be billed at the private pay rate of $18.00 per test. If the patient has a financial hardship, please include the hardship waiver for this charge to be waived. Our Private Pay Rate is currently $28.00, and our reduced Medicaid Private Pay Rate is $18.00.*

Secondary Insurance: _____ ID#: _____

Some Secondary Insurance Companies do not cover this service. The member will be responsible for the balance. Typical co-pays are between $5 - $15 but can be outside of these examples, depending on your Secondary Insurance Carrier.

DME Company (Respiratory Supplier)

DME: Olson Medical

Phone: (620) 421-2727 Fax: (620) 421-2744

Ordering Physician/Practitioner

Name: _____

NPI: _____

Testing Comments

Pulse Oximeter SN#: _____ Date/Start Time of Test: _____ Date/End Time of Test: _____

Test Condition: _____

Authenticity Statement, Assignment of Benefit & Medical Release

ADSI cannot release your test results to your physician without this signed form. Please read, sign & return this form with the oximeter or your test results cannot be released to your physician.

I, the undersigned, certify that I had the pulse oximeter dropped off by the DME Supplier, mailed by the DME supplier or I picked up the oximeter from the DME's office and was provided detailed, printed illustrated instructions by ADSI (Medicare Enrolled IDTF). Furthermore, I certify that I was the only person to test with this unit and that I did not alter or attempt to tamper with the unit in any way, shape or form. I authorize the DME Supplier to transmit the oximetry data to ADSI (Medicare Enrolled IDTF) to process these test results and release them to my ordering physician and DME Supplier. I authorize ADSI to exclude the first five minutes of test data and the last minute of test data as awake SpO2 for this nocturnal pulse oximetry.

I, the undersigned, authorize and release ADSI (Medicare Enrolled IDTF), to bill my primary and secondary insurance carrier(s) on my behalf for the cost of the overnight pulse oximetry. Furthermore, I authorize the payment to be made directly to ADSI for the cost of this oximetry test. I also understand that I am financially responsible for the amount that my insurance, primary and/or secondary, does not cover due to denial(s), co-pays, deductibles or coinsurances and will pay any bill received from ADSI promptly. In the event my insurance coverage has been terminated or I do not have insurance, I agree to pay ADSI the billed amount for this oximetry testing. ***Most state Medicaid plans, or Medicaid replacement plans, do not cover this procedure or we do not participate nor bill for this procedure to them & the patient will be charged at the reduced Medicaid rate specified above.***

I, the undersigned, authorize ADSI (Medicare Enrolled IDTF) to release my medical record chart pertaining to this overnight oximetry test to the above named DME Supplier and Ordering Physician/Practitioner. Furthermore, I authorize the DME Supplier to speak with my physician about any treatment, present or future, necessary based on the overnight oximetry results provided by ADSI. By signing below, I am confirming that I have read and understood this Medical Release and agree fully with the terms stated within.

The patient has the right to read our Notice of Privacy Practices before deciding whether to sign this Consent. Our notice provides a description of our treatment, payment activities and the use and disclosures we may make with your protected health information and other important matters about your protected health information. Below is a Notice of this Consent in which we encourage you to read carefully and completely before signing this Medical Release form.

Please note, ADSI maintains electronic files that may contain private information about you that may include but are not limited to your personal demographics and clinical records. We release, transfer & disclose the above information to the third parties to facilitate appropriate provision & review of services & billing for our clients of record. These files are legal documents & are also used for education, evaluating the performance of our organization, marketing & planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to, security precautions being in place in our building, billing software, transactions of data to third-parties, maintenance, retention & destruction of data, etc. You have the right to amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your record & have released to others upon request. If you have any questions concerning any of the above, please contact our office. **I've had the opportunity to read and consider this Consent form and Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.**

Patient Signature & Consent

X _____ Date: ____/____/____

Patient / Caregiver / Power of Attorney Signature (Patient Name: _____)

_____ Relationship to Patient: ○ Caregiver ○ POA ○Relative

Print Name, *if you're not the patient,* and mark your relationship to the patient.

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Watching Television	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting inactive in a public place, for example, a theater or a meeting	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
As a passenger in a car for an hour without a break	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Lying down to rest in the afternoon	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting and talking to someone	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
Sitting quietly after lunch when you've had no alcohol	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
In a car while stopped in traffic	0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
TOTAL SCORE		

A score of 10 or greater indicates a possible sleep disorder. Take the completed form to your doctor.