Vitalistics

Patient Name: _____ Healthcare Provider: _____

Date of Birth: _____ Phone: _____

Assignment of Benefits / Release of Medical Records

Vitalistics, Inc. is a CMS approved Independent Diagnostic Testing Facility "IDTF" that performs home sleep testing through an internet based platform. I understand Vitalistics will mail the home sleep testing device to my home and will provide a pre-paid mailer so that I may return the device after my test is complete. Your physician will receive a copy of the test via fax. Please contact our office if you have any questions. I agree and understand, as the under signer, that the home sleep test I just performed or that I am about to perform was ordered for me by my physician. This test is being used to measure oxygen saturations in my blood, heart rate, airflow, and my respiratory effort to determine if I may have sleep apnea. I authorize Vitalistics to perform and bill my insurance or Medicare on my behalf for the costs of this test. I understand that I will be financially responsible for the deductible and/or co pay and agree to pay any such out of pocket costs charged to me. If I am found to be ineligible by Medicare or other insurance providers too which Vitalistics submits a claim on my behalf, then I understand that I may be billed $150.00 for the cost of the testing. I verify that I am the recipient of the testing as described herein and that the test will be performed on me. I understand Vitalistics will provide me with clear instructions on how to apply the monitors for the home sleep testing. I also understand Vitalistics will provide me with a 24-hour contact phone number which I can call to ask any questions. In the event assistance is needed, I hereby authorize Vitalistics, to release information concerning this test and any medical information necessary to the provider of my medical care. This authorization will expire 180 days from the signature date and may be cancelled or dissolved in writing at any time.

Privacy Notice

Please be advised that Vitalistics retains electronic and paper files that may contain private information about you that may include, but are not limited to your dates of service, patient demographics, prescription, Healthcare Provider, physician information including care plan and diagnosis, progress notes, insurance coverage(s), purchases or rentals from Vitalistics, credit card numbers, etc. Vitalistics transfers & discloses the above information to the third parties to precipitate appropriate provision of healthcare services to include billing for our clients for services rendered. Your confidential files are also used within our organization for marketing & planning purposes as well as to maintain and increase quality as we strive to increase the performance and education of our organization. As required by law we maintain measures to protect patient health information. Vitalistics' security measures are in place to protect your information such as, but are not limited to, patient records, billing information, physician information, credit card information, supplier information, as well as wireless data transfer. As a Vitalistics customer you have the right to examine or obtain copies of the data that we have in your file & have released to others. You may also modify, prohibit or dissolve consent to release upon request. If you have questions concerning any topics listed above, please contact our office. As a Vitalistics customer I have had the opportunity to read and examine this Consent form and Vitalistics' Notice of Privacy Practices. I understand that by signing this consent form I hereby give my consent to Vitalistics to use and disclosure of my protected healthcare information to perform healthcare operations to include treatment and payment activities.

Notice of Privacy Practices

Please note that our Vitalistics customers have the right to read and receive our Notice of Privacy Practices before you sign this Consent. Vitalistics' notice provides you with an overview of our billing modalities as well as disclosures and uses of your healthcare information we may use or initiate.

Authorization to disclose HIPAA protected health information

I authorize Vitalistics, who will be receiving data from my home sleep test, to release the test data and reports to my physician or authorized healthcare provider who ordered the test. If my healthcare information is disclosed under the authorization to an individual who is not a health care provider, I understand the information will no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I understand that I also have the right to dissolve this authorization at any time excluding to the degree that Vitalistics has progressed in reliance on the authorization, by distributing or sending written notice or cancellation to Vitalistics.

Testing date **Signature of Patient** **Date**

PLEASE ATTACH TO THE PATIENT'S TEST FILE BY LOGGING INTO YOUR ACCOUNT AT VITALISTICS.COM OR YOU CAN FAX THIS FORM TO: (844) 550-9971

QUESTIONS CALL: 844-550-9970

Revision 4/22/2019