DELIVERY TICKET AND SLEEP DIARY

(Print, Sign, Date and Return)

www.blackstonemedicalservices.com
550 N. Reo St. Suite 250, Tampa, FL 33609-4524
Phone: (813) 831-2727

Patient Name (Please Print): _____

Patient Date of Birth: _____

Important Note: When study completed, please return this form with your name printed at the top, and signed and dated at the bottom, with the device. If therapy / treatment is required, the therapy provider may need to send this to your insurance carrier for further coverage.

Quantity: 1	**Provider: Blackstone Medical Services, LLC**
Type:	**Home Sleep Test/HST**

I, the above-named patient, have received a copy of the HIPAA Privacy Practices. I have received instructions on how to use the sleep study device over the phone, or by instructional video by a sleep technician, and also received written instructions included with the sleep study device. Customer support is also available to me by phone at 888-710-2727.

I hereby assign all medical benefits pertaining to the home sleep test to Blackstone Medical Services, LLC. I authorize the release of any medical or pertinent information regarding the home sleep test as necessary to obtain these benefits, to my insurance carrier, or any other medical entity, for continued medical care. I understand that it is my responsibility to report any changes in insurance coverage. I understand that I have been given an estimate of insurance coverage and that I am financially responsible for any amount not covered by my insurance per my contract and contracted rate with said insurance. By continuing with the home sleep test, I am acknowledging and agreeing to the Terms and Conditions, Privacy Policy, Refund Policy, Return Policy found at: https://www.blackstonemedicalservices.com/patient-support/home-sleep-test/

Night 1: **Night 2:**

Date of night 1: _____ **Date of night 2:** _____

Start time of night 1: _____ **Start time of night 2:** _____

Thank You,

_____ _____

Signature Date

PLEASE PRINT NAME AT TOP, AND SIGN AND DATE AT THE BOTTOM