AMERICAN HOME DIAGNOSTICS
PHONE (559) 916-4433 FAX (866) 483-1981 FRESNO, CA 93720
american.home.diagnostics.com

REFERRAL FORM

Patient Name:_____ DOB: _____ SS#_____
Last First MI

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Height: _____ Weight: _____ Neck Circumference:_____ Oxygen Use (Y/N): _____ LPM: _____ Sex: (M/F): _____

Circle One: Single Married Divorced Separated Widowed Employer (if applicable):_____

Nearest Relative (not living with patient): _____ Relationship: _____ Phone: ( ) _____

INSURANCE

Policyholder Name: _____ Relationship to patient:_____

Policyholder ID#_____ Policyholder SS#_____ Policyholder DOB:_____

Name of Ins. Co._____ Group #_____ Name of Employer:_____

Home Address:_____City:_____State:_____Zip:_____

Home Phone:( )_____ Cell Phone: ( ) _____ Work Phone: ( )_____Email: _____

Please include secondary insurance information if applicable.

SYMPTOMS & REASON FOR REFERRAL

- ☐ **Excessive Daytime Sleepiness**
- ☐ **Morbid Obesity**
- ☐ **Cardiac Disease Type_____**
- ☐ **COPD**
- ☐ **Diabetes**
- ☐ **Snoring**
- ☐ **CHF**
- ☐ **Hypertension**
- ☐ **OSA**
- ☐ **Restless Leg Syndrome**
- ☐ **Narcolepsy**
- ☐ **Insomnia**
- ☐ **Periodic Limb Movement Disorder**
- ☐ **Frequent Awakenings**
- ☐ **Bariatric Surgery To Follow**
- ☐ **Parasomnia**

SLEEP DISORDER DIAGNOSTIC SERVICE

☑ **Comprehensive Sleep Study** (PSG/Titration/3 Night HST), **Evaluation**: by Board Certified/Eligible Sleep Specialist to determine and order appropriate testing procedure.

Three (3) Night Unattended Home Sleep Study: Home Sleep Study (HST) OR _____ - Night Unattended Home Sleep Study

☐ **Three (3) Night Unattended Home Sleep Study:** Home Sleep Study (HST) OR _____ - Night Unattended Home Sleep Study

Special Instructions_____

STATEMENT OF MEDICAL NECESSITY

Referring Physician: _____ **NPI:** _____ **License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:**_____ **Email:** _____

Physician Signature: _____**Date:** _____

Please attach patient's clinical history, medications, physician's notes, demographics, & insurance information

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ASSIGNMENT OF BENEFITS

Thank you for choosing American Home Diagnostics. We are committed to treating our patients in a professional and caring manner. This statement of our financial policy defines the patient's (your) financial responsibility to American Home Diagnostics and which we require you, as the patient (or legal guardian of patient), to read and sign before we can render any services.

The undersigned patient and /or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered, assigns to American Home Diagnostics the following rights, power, and authority:

ASSIGNMENT OF BENEFITS: American Home Diagnostics is assigned the right to any cause of action that exists in my favor against any insurance company or other persons or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment directly for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company or other entity. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. American Home Diagnostics is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me for treatment rendered by American Home Diagnostics, you are hereby rendered demand to pay the provider directly in full the bill for services rendered by American Home Diagnostics following your receipt of such bill for service to the extent such bills are payable under the terms of my policy for benefits, less any amounts that I owe personally which are not payable under the terms of my policy benefits.

STATUTE OF LIMITATIONS: I waive the right to claim any Statute of Limitations regarding claims for services rendered by American Home Diagnostics.

ATTORNEY FEES: I agree to pay for reasonable costs of collection (both pre and post judgment) for services rendered by American Home Diagnostics if my account is assigned to an outside agency for pursuit of collection of unpaid balances. The undersigned agrees to pay all attorney fees, court costs, filing fees, and interest upon the unpaid balance at that rate permitted by law, as assessed to the undersigned by any agency retained to pursue this matter with or without suit.

All authorizations are applicable for any services rendered by a medical provider billing separately for their services at American Home Diagnostics.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULY AUTHORIZED TO EXECUTE THE ABOVE AND TO ACCEPT ITS TERMS.

Printed Name: _____ Date: _____

Signature:_____ Witness: _____