YOU ARE PERFORMING AN OVERNIGHT OXIMETRY TEST.
THIS TEST WILL BE BILLED TO YOUR INSURANCE BY BREATHE.

ASSIGNMENT OF BENEFITS.

My signature below indicates that I understand and agree that my physician ordered the oximetry test just taken for the purpose of verifying my need for home oxygen in relation to my pulmonary disease. Further, I hereby authorize and release **BREATHE**, an independent diagnostic testing facility, to bill my insurance carrier(s) and/or Medicare on my behalf for the costs associated with this testing. **I understand that I may be financially responsible for any deductibles and/or copay amounts, and agree to make the $38.00 payment if it is determined that either has not been met at the time of billing**. I understand that I am financially responsible to **BREATHE** for any charges not covered by health care benefits. It is my responsibility to notify **BREATHE** of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by **BREATHE** and/or my health care insurer if the submitted claims or any part of them are denied for payment.

STATEMENT OF AUTHENTICITY / MEDICAL RELEASE

I understand by signing below, that I am accepting financial responsibility as explained above for all payment for products and/or services received. I authorize **BREATHE** to release information concerning this test and any medical information necessary to inform the provider(s) of my medical care per results of testing.

I, _____(Patient's Name) _____(Address) ___/___/____(Date of Birth) hereby release my medical record to my prescribing/referring physician, and my home care provider of choice. My signature on this form gives the right to release medical records to my home care provider.
Information to be released to:

_____ _____
Company/Individual Name Phone

_____ _____
Address Fax

_____ **Date** _____ **Height** _____ **Weight** _____
Patient's Signature Relationship if Patient cannot sign: _____

Date _____ Oximetry performed on: ____Room Air ____PAP ____Oxygen at ____LPM
Pulse Oximeter Model:_____ Serial Number:_____

Please answer the following questions to help us better assess your respiratory needs. This information will be forwarded on to your health care provider.

0 = No chance of dozing **1 = Slight** chance of dozing **2 = Moderate** chance of dozing **3 = High** chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. - in a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon with circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

RESPIRATORY HISTORY		
Are you ever short of breath?	Yes	No
Does your shortness of breath occur at rest?	Yes	No
Does your shortness of breath occur with activity?	Yes	No
Are you short of breath at night?	Yes	No
Do you smoke now or have you ever smoked?	Yes	No
Do you use a nebulizer or inhalers for shortness of breath?	Yes	No
Do you wake up with morning headaches?	Yes	No
Do you wake up feeling tired and un-rested?	Yes	No
Have you noticed or been told that you snore?	Yes	No
Do you use a CPAP machine?	Yes	No
Do you have high blood pressure?	Yes	No

BREATHE
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