## 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 <b>BR</b> inform the provider(s) of my med	<b>EATHE</b> to release information concerning this test and any n ical care per results of testing.	nedical information necessary to
I,	(Patient's Name)	(Address)
	by release my medical record to my prescribing/referring physorm gives the right to release medical records to my home care	· · · · · · · · · · · · · · · · · · ·
Information to be released to:	sam gares une rigino de recouse meurous seconds de my nome our	F 120 120021
Company/Individual Name	Phone	
Address	 Fax	

Please answer the following questions to help us better assess your respiratory needs. This information will
. Diagga angreen the tellowing apportions to halp us botton assaus value nagninatons needs. This intemmetion will

forwarded on to your health care provider.

Date \_\_\_\_\_ Oximetry performed on: \_\_\_\_Room Air \_\_\_\_PAP \_\_\_Oxygen at \_\_\_\_LPM

 $0 = N_0$  chance of dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation		<b>Chance of Dozing</b>			
Sitting and reading		1	2	3	
Watching TV	0	1	2	3	
Sitting inactive in a public place (i.e in a theater or a meeting)		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		1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	

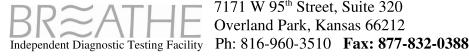
Patient's Signature Relationship if Patient cannot sign:

Pulse Oximeter Model:\_\_\_\_\_

RESPIRATORY HISTORY		
Are you ever short of breath?		No
Does your shortness of breath occur at rest?		No
Does your shortness of breath occur with activity?		No
Are you short of breath at night?		No
Do you smoke now or have you ever smoked?	Yes	No
Do you use a nebulizer or inhalers for shortness of breath?		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

Date Height Weight

Serial Number:\_\_\_\_\_



7171 W 95th Street, Suite 320 Overland Park, Kansas 66212