Sleep Disorders Institute Midwest
Phone (913) 754-3275 Fax (913) 754-3276
sleepdisorders@kc.rr.com

11881 W. 112th St. Suite 101
Overland Park KS 66210

2331 Alabama, Ste 101
Lawrence, KS 66046

3601 S 4th st., Ste 8
Leavenworth, KS 66048

104 N Hwy 7, Ste J
Blue Springs, MO 64014

Patient Authorization Form

I, _____ authorize the Sleep Disorders Institutes to perform Polysomnography (sleep study) procedures. These procedures will be used for diagnostic, therapeutic or research purposes.

Long term EEG monitoring and Polysomnography procedures are non-invasive multi channel recordings designed to record diagnostic physiologic parameters for neurological or sleep disorders. Monitoring leads are attached with tape or snap electrodes and medical crème. Minor skin irritation associated with the cleaning of the application sites and tape may be a side effect of the procedure.

When Continuous Positive Airway Pressure (CPAP), BiLevel pressure or oxygen is indicated by policy during a sleep study, it may be applied to improve cardiac or respiratory events occurring during sleep. Common complications of CPAP and BiLevel are dry mouth; burning sensation in the nose, and skin irritation, with any procedure, there may be unforeseen or unexpected side effects experienced. Notify the technologist of any discomfort you experience during your procedure.

I understand there is a possibility of reactions associated with tape.

I understand and consent to the recording with video, before or during the procedure by the technologist. All photographic documentation is kept confidential and to be used as part of the therapeutic, diagnostic, teaching or research procedure only.

Please note that all labs have monitoring cameras for the technologist to view patients. The presence of a camera is used for diagnostic purposes and used to assure your safety and the technologist safety.

I certify that:

- I have read and have access to a copy of the Consent Form and the Patients Rights brochure.
- I give permission to release medical information pertinent to my care to my insurance or to my consulting physicians.
- I authorize Sleep Disorders Institute Inc. to bill my insurance company for services, supplies and or treatment provided to me. I understand any balance not covered by insurance will be my responsibility.
- I release Sleep Disorders Institutes Inc. or its agents from any liability or damages that may occur from the disclosure of such information in pursuit of payment.
- I understand the nature and purpose of the procedure, the risks involved and the possibility of complications.

_____ _____ _____
Print Name Relationship Date

_____ _____
Signature of Patient or Responsible Party Witness