Appointment Date
_____/_____/_____

Home Sleep Test (HST) Consent and Release Form

Patient Name:_____DOB: _____/_____/_____

Address:_____City:_____State:____Zip: _____

Home Phone:_____Cell Phone:_____Email: _____

I. **Consent and Release**: I give my permission to AMDx, Ltd., dba NeuroDiagnostic Laboratories (hereinafter "AMDx") staff to conduct the home sleep test, and any activities associated therewith. I hereby expressly waive any and all claims, which I might, now or at any future date, assert against AMDx or its employees, agents, assignees, designees, or successors in interest arising from the performance of this test / study, as well as any claims arising from any ancillary activity necessary to effectuate the test/study. I have been given reasonable opportunity to read about and ask any questions I may have about the risks associated with, about sleep apnea, and I affirm that I do not hold AMDx, Ltd., its employees, agents, assignees, designees or successors in interest responsible if I elect to refuse treatment.

Equipment lease date: _____

Expected equipment return date:_____ *Return by 11:00 AM local time*

Equipment serial number: _____

I understand that:

I. Delays in the return of equipment are subject to a late fee of $250.00 per day. I expressly authorize these fees to be charged to my credit card ending in_____.

II. My failure to return the equipment within 72 hours of the "Equipment return date" this will be considered theft of the equipment provided me for the purpose of conducting the test / study. After this 72 hour period has expired, I authorize AMDx to charge the full amount of the equipment ($2500.00) to my credit card ending in_____. In the alternative, I understand that AMDx may elect to report the equipment as stolen and file criminal charges with the appropriate law enforcement agency pursuant to the Arizona Criminal Code, codified at A.R.S. Title 13 §13-1806.

III. I understand that I will be charged for any and all incidental damages that AMDx incurs due to my failure to make a timely return of the rented equipment to AMDx, and I authorize these charges to my credit card ending in_. Incidental damages include: charges relating to loss of revenue from future test/study patients where AMDx is unable to furnish diagnostic equipment because of my failure to return it; replacement cost fluctuations that result in an increased purchase price, as well as other costs associated with procuring a replacement unit, such as, but not limited to, shipping, storage, sales commissions, "rush order" fees, and any other charge so related. This provision is inserted pursuant to A.R.S. Title 47 §47- 2A530, otherwise titled Arizona's Uniform Commercial Code.

IV. In the event that AMDx must incur costs related to enforcing any provision contained in this agreement, I shall be liable for all court, filing, and attorney's fees.

Neuro Diagnostic
Sleep Centers

Appointment Date
_____/_____/_____

I HAVE BEEN ADVISED OF, UNDERSTAND, AND AGREE TO THE PROVISIONS OF THIS AGREEMENT, AND FURTHER AGREE THAT THE PROVISIONS CONTAINED HEREIN REPRESENT THE ENIRETY OF THE AGREEMENT BETWEEN ME AND AMDX:

Patient Name (printed):_____

Patient Signature: _____ Date:_____/_____/ _____

If applicable, please print the name of the patient's representative:

_____

Relationship to the patient: _____

Representative Signature: _____

NeuroDiagnostic Sleep Centers

Appointment Date
_____/_____/_____

Home Sleep Test (HST) Instruction Acknowledgement

Patient Name: _____ Patient DOB: ____/____/____

HST serial number: _____

Check out date: ____/____/____ Location: _____

Return date*: ____/____/____ Location: ☐ Phoenix ☐ Mesa

**** Please expect to wait 5-10 minutes at the time of return while we download your HST results. Ensure that you speak to the front desk receptionist and receive confirmation that all results were successfully downloaded before leaving our office.***

I acknowledge that a NeuroDiagnostic Laboratories team member has provided me with instruction and/or demonstrated how to use the ApneaLink Air Home Sleep Testing Device and I understand what is required. Further, I have been provided instructions in the event I need assistance while setting up the device at home.

- Instruction packet located in HST case
- ResMed instructional video: https://youtu.be/awa4z2fFn7A
- (602) 424-4450 EXT 512

Patient Name (printed): _____

Patient Signature: _____ Date: ____/____/____