

SLEEP DIAGNOSTICS, INC.

Helena Office

900 N. Montana Ave. Ste A9
Helena, MT 59601
Phone (406) 449-8999
Fax (406) 449-8989

Missoula Office

1211 S. Reserve, Ste 203
Missoula, MT 59804
Phone (406) 542-4784
Fax (406) 543-1150

Butte Office

400 W. Granite
Butte MT. 59701
Phone (406)782-4595
Fax (406) 782-4355

Dear Valued CPAP Patient,

We are excited to offer a convenient new auto-ship program for your CPAP supplies. Keeping your CPAP equipment maintained and supplies changed on a regular basis will improve the effectiveness of your treatment.

We will mail any supplies you request to your home automatically on a recurring basis of your choice (that does NOT exceed insurance allowables). Our goal is to create a convenient way for you to receive your supplies by eliminating travel costs and the need to make appointments. Shipping is \$20.00 per year cost to the patient and we will bill your insurance for the supplies.

Standard insurance co-pay and deductibles will apply.

It is easy to enroll. Just fill out the included form with your choices and mail it back to us in the provided envelope. This program is completely optional but we would appreciate it if you could take the time to mail the form back even if you are not interested at this time.

**THIS PROGRAM WAS DESIGNED FOR PATIENT CONVENIENCE ONLY!
YOU CAN CALL AND CANCEL OR CHANGE ORDER AMOUNTS AT ANY TIME!!!**

If you have any questions about this program please call

*Thank you,
Sleep Diagnostics, Inc.*

Patient Name: _____ **DOB:** _____ **Date of Set Up** _____
Phone # _____ **Email** _____
Current Insurance _____ **ID #** _____ **Grp #** _____

PLEASE FILL IN THE INFORMATION BELOW:

CPAP MACHINE MANUFACTURER AND MODEL: _____
 FULL FACE FRAME AND CUSHION STYLE: _____ SIZE: _____
 NASAL MASK FRAME AND CUSHION STYLE: _____ SIZE: _____
 NASAL PILLOW FRAME AND CUSHION STYLE: _____ SIZE: _____
 HEADGEAR STYLE: _____ SIZE: _____
 HEATED TUBING STYLE: _____ SIZE: _____
 NON-HEATED TUBING LENGTH (STANDARD IS 6 FT): _____
 HOW LONG AGO (APPROXIMATELY) SINCE YOU GOT YOUR LAST MASK? _____

| <u>PRODUCT</u> | <u>ALLOWED AMOUNT</u> | <u>FREQUENCY CHOICE</u> | <u>Start sending these specific supplies on this MONTH and YEAR</u> |
|---------------------------------------|-----------------------|-------------------------------------|---|
| MASK FRAME NASAL OR FULL FACE | 1 EVERY 3 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| EXHALATION PORT | 1 EVERY 3 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| HEADGEAR | 1 EVERY 6 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| MASK CUSHION (nasal or nasal pillows) | 2 PER MONTH | 2 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| MASK CUSHION (full face) | 1 PER MONTH | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| TUBING (non- heated) | 1 EVERY 3 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| TUBING (heated) | 1 EVERY 3 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| DISPOSABLE FILTERS | 2 PER MONTH | 2 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| WATER CHAMBER *PAID BY PATIENT | \$40.00 CASH FEE | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |
| NON DISPOSABLE FILTER | 1 PER 6 MONTHS | 1 EVERY <input type="text"/> MONTHS | <input type="text"/> |

SPECIAL NOTES/REQUESTS:

Please ship me the supplies checked starting on the month and year that is stated above.
This invoice is valid for one year from the date of signature.

- Assignment of Insurance Benefits: I authorize Sleep Diagnostics, Inc. any insurance benefits otherwise payable to me for the services provided to me by Sleep Diagnostics, Inc. I also authorize my insurance companies to furnish to an agent of Sleep Diagnostics, Inc. any information pertaining to my insurance benefits and status of claims submitted by Sleep Diagnostics, Inc. for services rendered. I further authorize Sleep Diagnostics, Inc. to release to my health insurance companies and all information pertaining to me for benefit determination.
- Acknowledgement of My Financial Responsibility: I understand that my insurance coverage may not pay the total cost of the service provided to me by Sleep Diagnostics, Inc. I acknowledge my obligation to pay the balance between what my insurance coverage will pay and what Sleep Diagnostics, Inc. can charge for these services. I agree to remit Sleep Diagnostics, Inc. any payments made directly to me by my insurance company for services provided by Sleep Diagnostics, Inc.
- I understand that should I default on my payment of my account and collection agency services are required, all costs of collection, including attorney fees will be added to the balance of my account.
- I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 45% of the balance, including attorney/court costs will be added to the balance of my account. This agreement shall remain in effect for all services provided within the 90 days from the date of signing this agreement.
- I agree to authorize an annual shipping charge of \$10.00 that will be assessed to my account and is not covered by insurance.

Patient Signature _____ **Date** _____