DESERT PULMONARY REHAB & DIAGNOSTICS, LLC

DISCLOSURE, ACKNOWLEDGEMENT, RELEASE AND PERMISSION TO BILL FOR SERVICES

MEDICAL CONSENT / DIAGNOSTIC TESTINGS

I, _____ (Patient Name) give my permission to Desert pulmonary rehab & Diagnostics, LLC to perform any respiratory diagnostic testing order by my physician including but not limited to pulse oximetry testing, sleep study, bedside PFT, asthma education including peak flow training, aero chamber training, bronchospasm / exercise induce evaluation with simple pulmonary stress testing, bronchial hygiene therapy and lung expansion therapy and pulmonary rehab.

_____For IN-HOME SLEEP STUDY, I acknowledge and understood that I am solely responsible financially for the sleep equipment for any damage, stolen or lost given to me by the clinic to be in my possession to take home to evaluate my sleep apnea.

FINANCIAL AGREEMENT / ASSIGNMENT OF BENEFITS

I hereby agree to allow Desert Pulmonary rehab & Diagnostics, LLC to bill my medical / health insurance for any of the respiratory diagnostic testing as stated above order by my physician. I agree to accept full financial responsibility for payments of any the above testing as order by my physician. I furthermore authorize Desert Pulmonary rehab & Diagnostics, LLC to request on my behalf, and directly collect all insurance benefits for any of the respiratory diagnostic testing as order by my physician. In the event payment for insurance benefit is made directly to the beneficiary, the payee will endorse to Desert Pulmonary Rehab & Diagnostics, LLC all such payments.

RELEASE OF INFORMATION

I authorize all medical personnel to provide Desert Pulmonary rehab & Diagnostics, LLC any medical information / history required by third party for billing purposes. I also acknowledge the receipt of this Disclosure, Acknowledgement and Release and hereby release Desert Pulmonary rehab & Diagnostics and its agents, employees, and representatives, from all claims, liabilities, and causes of actions during testing ordered by my physician.

PATIENT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____