



Patient Name _____

Study Date _____

Study Time _____

Reason for Study _____

Your physician is sending you to Sleep Medicine Associates, PC and the Southwestern Indiana Sleep Disorders Center for sleep testing. Our goal is to provide the highest quality sleep testing services in a comfortable, patient friendly atmosphere. You will be contacted by our office within seven to ten days to discuss the details of your sleep testing. In the meantime, if you have any questions concerning your testing, you may contact our office.

We appreciate the confidence that you and your physician have shown in us by selecting us to provide your sleep testing services.

Testing Compliance (“No Show”) Policy

Please read carefully. The following testing compliance policy has been implemented to ensure that the practice can provide the highest quality testing and care to our patients.

Your physician has recommended that you have a sleep study as part of the diagnosis, or treatment of a sleep disorder. Sleep studies are typically scheduled in advance with resources allocated by Sleep Medicine Associates, PC to perform the testing. These resources include the study room and equipment, and sleep technician time. It is the expectation of Sleep Medicine Associates, PC, that patients scheduled for testing will keep their sleep study appointment. **Patients who fail to keep their sleep study appointments will be charged a “no show” fee of \$150.00, or may not be rescheduled for testing, or both.**

Changes to testing appointments must be made at least 48 hours prior to the testing date, and during regular office hours, Monday-Friday, 8 am to 4:30 pm. Changes to weekend appointments (Saturday or Sunday) must be made no later than Thursday morning.

I have read and understand the testing compliance policy.

Signed _____ Date _____

Date of Study _____