Home Sleep Testing Agreement& Letter of Authorization

Patient Name: _____ Phone: _____

Address: _____

DOB (DD/MM/YYYY)_____

Referring Dental Practitioner / Hygienist: _____

Home Sleep Test Device:

Philips Respironics Stardust II Serial # _____

Check out date (DD/MM/YY): _____ Return by (DD/MM/YY): _____

No deposit required.

Credit Card Type: Visa MasterCard

Credit Card No: _____

Expiry Date (DD/MM/YY): _____ Last 3 digits on back of the card (CVV#): _____

I authorize SleepMed Corp. to charge my Credit Card for the full amount of the home testing unit of $2000 if I fail to return all equipment in good working condition by the date set out above.

Client Signature:_____ Date(DD/MM/YY)_____

Clinician Signature:_____ Date(DD/MM/YY)_____

By signing this agreement, you are aware and fully responsible for the full cost of the medical equipment provided, within the rental period stated in this agreement. Failure to comply with the terms of this rental agreement will result in SleepMed Corp. charging the full cost of the medical equipment to the credit card provided on file. Or resulting in your file to be sent to Firstline Credit Management Inc., a third party collection agency, that will collect the outstanding balance for SleepMed Corp.