Sleep EZ Family and Sleep Health LLC
13241 Bartram Park Blvd
Suite 2009 and 2013,
Jacksonville, FL. 32258

Appointment Date: _____

Home Sleep Test (HST) Instruction Acknowledgement

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

HST serial number: _____

Check out date: _____/_____/_____

Return date: _____/_____/_____

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

I acknowledge that a Sleep EZ Family and Sleep Health LLC team member has provided me with instruction and / or demonstrated how o use the Alice night one home sleep testing device and I understand what is required. Furthermore, I have been provided instructions in the event I need assistance while setting up the device at home.

- Instruction packet located in the HST device case
- Philips Respironics Alice night one instructions: https://www.usa.philips.com/healthcare/product/HC1109289/alice-nightone-home-sleep-testing-device
- (833)-41-Sleep (833-417-5337

Patient Name (printed) :_____

Patient Signature: _____ Date: _____/_____/_____