Sleep EZ Family and Sleep Health LLC Appointment Date: _____

Home Sleep Test (HST) Consent and Release Form

Patient Name: _____ DOB: _____/_____/_____

Address: _____ City_____ State: _____ Zip_____

Consent and Release: I give my permission to Sleep EZ Family and Sleep Health LLC staff to conduct the home sleep test and any activities associated therewith. I hereby expressly waive any and all claims which I might now or at any future date assert against Sleep EZ Family and Sleep Health LLC or its assignees, employees, designees or successors in interest arising from the performance of this test/ study, as well as any claims from any ancillary activity necessary to effectuate the test/ study. I have been given reasonable opportunity to read about and ask any questions I may have about the risks associated with about sleep apnea and I affirm that I do not hold Sleep EZ Family and Sleep Health LLC, its assignees, employees, designees or successors in interest responsible if I elect to refuse treatment.

Equipment release date: _____

Expected equipment return date: _____ Return by 11:00 AM local time

Equipment serial number: _____

I understand that:

1) Delays in the return of equipment are subject to a late fee of $ 250.00 per day. I expressly authorize this fee to be charged to my credit card # _____.
2) My failure to return the equipment within 72 hours of the "Equipment return date", this will be considered theft of the equipment provided me for the purpose of conducting the test/ study. After this 72 hour period has expired, I authorize Sleep EZ Family and Sleep Health LLC the full amount of the equipment ($2500.00) to my credit card #_____. As the alternative, I understand that Sleep EZ Family and Sleep Health LLC may elect to report the equipment as stolen and file criminal charges with appropriate law enforcement agency pursuant to the Florida Criminal code. § **817.535**
3) I understand that I will be charged for any all incidental damages that Sleep EZ Family and Sleep Health LLC incurs due to my failure to make a timely return of the released equipment to Sleep EZ Family and Sleep Health LLC and I authorize these charges to my credit card # _____. Incidental damages include: charges relating to loss of revenue from future test/ study patients where Sleep EZ Family and Sleep Health LLC is unable to furnish diagnostic equipment because of my failure to return it; replacement cost fluctuations that result in an increased purchase price, as well as other costs associated with procuring a replacement unit, such as but not limited to shipping, storage, sales commissions, "rush order" fees and any other charge so related. This provision is inserted pursuant to Florida Uniform Commercial Code.
4) In the event that Sleep EZ Family and Sleep Health LLC must incur costs related to enforcing any provision contained in this agreement, I shall be liable for all court, filing and attorney's fees.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS AGREEMENT AND FURTHER AGREE THAT THE PROVISIONS CONTAINED HEREIN REPRESENT THE ENTIRETY OF THE AGREEMENT BETWEEN ME AND SLEEP EZ FAMILY AND SLEEP HEALTH LLC :

Patient Name (printed) : _____

Patient Signature: _____ Date: _____/_____/_____

If applicable, please print the name of the patient's representative:

_____

Relationship to the patient: _____

Representative Signature: _____