Sleep EZ Family and Sleep Health LLC
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No - Show Penalty and Incidentals Form

Failure to cancel any checked appointments 72 hours in advance will result in the following penalties. You are responsible for the incidentals. You will be contacted by phone, text, or e-mail.

A) Patient's Name, Last_____, First_____ Middle: _____

B) Patient's Legal Guardian Name, Last_____, First _____. Middle_____

C) Patient's Address_____

D) Patient's Phone Number:_____ Patient's Email: _____

E) No show fee,

1) No show sleep office consult penalty fee: $175.00

2) Failure to cancel scheduled home sleep study or failure to drop off home sleep study equipment penalty fee: $300.00.

3) Failure to cancel scheduled in sleep laboratory sleep study penalty fee: $425.00.

4) Incidental's fee: $1000.00

5) Method of Payment:

1) ---------- Check,

2) ___ Credit card number _____ exp date _____ three-digit security code ____ zip code _____

*** Note:** American Express credit card *NOT* accepted.

F) For security reasons do not send this form with credit card information via email. Submit this form in person, via fax or mail.

G) By signing and submitting this form, I (patient/ patient's legal guardian) _____ understand that I am subject to all or any of the above checked penalties. understand any false statements/information made on this form will constitute legal consequences. I also certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is made in good faith

H) Patient's signature:_____Date: _____

I) Patient's legal guardian's signature:_____Date: _____

All Forms must be signed by the patient or patient's legal guardian. No third-party requests will be accepted.