The REM Center™

A Premier Sleep Assessment Facility

(a division of Braaten Health, LLC)

www.remcenter.com

Welcome to the REM Center. In order to serve you properly, we will need the following information.
All information will be kept strictly confidential.

Name: (Last)_____ (First) _____ (MI) _____

Address: _____ City: _____ State: _____ Zip code:_____

Home Phone: _____ Alternate phone: _____

Social Security No: _____ Birth date: _____ Age: _____

Employer: _____ Employer phone: _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed Sex: ☐ Male ☐ Female

Spouse's Name:_____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Employer phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Referring Physician: _____

Acknowledgement of notice of REM Center Privacy Practices

By signing this document, I acknowledge that I am aware of the REM Center Notice of Privacy Practices.

_____ _____ _____

Name (Print) Signature Date

REM Center Consent Form

I, _____ authorize a _____ to be performed under the medical direction of _____.
(Patient Name) (Procedure) (Interpreting Physician)

- The nature and purpose of this test as well as the risks involved and possible complications have been fully explained to me.
- No individual with The REM Center or physician's office has given me a guarantee or assurance as to the results that may be attained.
- I have been informed prior to tonight that the technician performing the study may be of the opposite sex and have agreed to continue with the test.
- I understand that a photograph will be taken and video monitoring and recording will be preformed as part of the diagnostic test.
- I hereby give permission to release any medical information on myself that may be deemed necessary as part of this procedure.
- I understand and consent to results of this procedure being released to other physicians deemed necessary in my continued care.
- I do consent to the release of medical records in the process of filing insurance claims.
- I understand the billing of this procedure will be managed by The REM Center and/or Braaten Health and assign any benefits paid on my behalf to The REM Center.
- I understand that a separate bill will be filed to my insurance carrier for the interpretation by the interpreting physician.
- I understand that I am financially responsible for any amount not covered by my insurance carrier.
- The REM Center and its employees are not responsible for any loss or damage to personal items I have brought to the sleep lab.

_____ _____

(Patient/Guardian Signature) (Witness)

_____ _____

(Date) (Date)