1038 W. North Blvd, Suite 201
2nd Floor
Leesburg, Fl 34748

SLEEP STUDY INSTRUCTIONS/WAIVER

Patient Name: _____ Study Date & Time: _____

INSTRUCTIONS:

1. Please arrive @ scheduled appt. time either 8:00pm or 9:00pm and be aware that you will leave around ***5:00am*** the next morning.
2. Please refrain from taking any naps or drinking caffeine the day of your study.
3. Please bring all of your medications with you that you would normally take at night when you are going to sleep. If you use a Nebulizer, or inhaler bring these medications with you to use if necessary.
4. If you are on portable oxygen, please bring your tank with you so that you can use it while you travel to the office if necessary. If you are on oxygen only at night with a concentrator, please be aware that we have concentrators in each room for your use. You will only need to bring your tubing, mask or mouthpiece for your convenience.
5. If you already use CPAP or BIPAP please bring your mask. You will use our machines since they are connected to our computers. You will be able to use your masks, although you will have the option of trying out different masks if your current mask is not giving you the best results possible.
6. Please bring comfortable sleep wear, (women please wear a 2 piece pajama) and a face towel or cloth.
7. Please have your evening meal before arriving for your sleep study. You are welcome to bring a snack with you if you would like. There is a refrigerator on premises.
8. Please take a shower before arriving for your sleep study and if you need to shampoo your hair please do so, however please do not use any conditioner. Please do not come to lab with any hairspray, gel, weave, wig, etc. in your hair prior to coming for your study.
9. Please note the sleep technologist cannot discuss results of the sleep study with you.
10. Please note that given the complexity and the enormous amount of data that needs to be carefully analyzed for your benefit. Our office will contact you with the results of your sleep study on or about two (2) weeks from the night of your study.

PLEASE NOTE:

*****We require a verbal confirmation from the patient for this test.
*****We require at least **24 hour notice** if you need to reschedule your appointment. There is a **$200.00 charge** if you do not show for your appointment without proper notification to our office.
*****I understand if I do not complete the entire sleep study this evening by my own choice that I am responsible for the payment of the test in full.
*****I understand that a recording of each patient's words, behavior and interaction with the technician begins as soon as the patient enters the sleep lab room and continues until the patient leaves in the morning. During the night microphones continue to record snoring or words and the infrared cameras document any patient movements. I give my permission for such recordings that can provide very useful information to diagnose and manage my sleep problems. Visual and audio recordings can be archived or erased at the discretion of Pulmonary Group of Central Florida Sleep Lab, depending on their contributions to patient's clinical care.
***** *You may be billed a professional fee from Dr. Javier for interpretation for* ***Medicare patients only****.*
*****Patient's may be billed a co-pay or co-insurance depending on your healthcare benefits. Contact your insurance for patient responsibility.***
*****Please be sure we have your most current Insurance cards on file for medical services coverage**.

Sleep Lab telephone # 352-504-0967 (7:00pm-5:00am only) Monday-Friday or call the office @ 352-315-1627

Patient Signature: _____ __Date: _____

Witness Signature: _____ Date: _____