I give consent to the Sleep Center of Central Illinois LLC to perform polysomnographic testing on myself and initiate appropriate therapy. ___________
Initial

I give consent to be photographed and/or recorded while at the Sleep Center of Central Illinois. I understand that only the interpreting physician and appropriate staff will see these images. ___________
Initial

Authorization to release information and to pay benefits to Sleep Center of Central Illinois LLC. I hereby authorize the Sleep Center of Central Illinois LLC to release any information acquired in the course of my treatment, and, if applicable, hereby assign payment directly to the Sleep Center of Central Illinois LLC the medical benefits, if any, otherwise payable to me for services, but not to exceed the charges for these services. I understand that I am financially responsible for the charges not paid by insurance.

Emergency Contact: ____________________ _____________ ____________________
Name Relationship Phone Number

Emergency Contact: ____________________ _____________ ____________________
Name Relationship Phone Number

___________ ______________________________
Date Signature