Sleep Solutions of Fredericksburg
521 Park Hill Drive, Suite B
Fredericksburg, VA 22401
Phone: (540)372-6430
Fax: (540)372-6847

Informed Consent Form

I, _____ (patient name), authorize and direct the medical staff at Sleep Solutions of Fredericksburg to perform a polysomnogram (sleep study) upon me.

My physician has explained to me the nature of the study and procedure, and the Indications for accurate diagnosis and treatment of my underlying sleep disorder/ problems. There is no guarantee, however, as to the results of the study or cure of my sleep disorder or problems.

I have also been informed that I can have this procedure done in other sleep centers, but I have freely chosen to do this study at Sleep Solutions of Fredericksburg.

You will be charged in accordance with the guidelines specified by your insurance company.

My signature below acknowledges that I have received the information I need regarding the procedure, have read and agreed to the foregoing, and fully consent to the performance of the procedure(s) indicated above.

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date