SLEEP SCIENCE CLINICS (TEXAS)
7215 WYOMING SPRINGS, STE. 600, ROUND ROCK TX 78681
800 BRAZOS STREET, STE. 1400, AUSTIN TX 78701
TEL: 512.255.2727 FAX: 512.255.6277

DURABLE ASSIGNMENT OF BENEFITS
AND
PAYMENT AUTHORIZATION

Date: _____

Insurance(s): (A photo copy of your insurance card should be attached with this document)

Subject: Patient Name: _____

DOB: _____

To Whom It May Concern:

I, _____, authorize payment of medical service(s) to the provider, Sleep Science Clinics LLC, Inc or all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Please mail check payable to:

SLEEP SCIENCE CLINICS, LLC
7215 Wyoming Springs, Suite 600
Round Rock, Texas 78681

Thank you.

Effective Date of Authorization: _____ _____
(Signature)

_____
(Print Name)

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Patient Name: _____ Date of Birth: _____

Type of Study: _____ Date of Study: _____

FOLLOW-UP VISIT

1. Are there any changes in the medications you are taking?

_____

_____

_____

2. Have there been any changes in your medical condition since your last visit here?

_____

_____

_____

Patient Signature: _____

Print Name: _____