KAIROS SLEEP CLINIC

PATIENT ACKNOWLEDGEMENT & CONSENT FORM (PAGE 1 OF 2)

Please read each section carefully. You can complete this form directly on your computer or print it out to fill by hand. Ensure all checkboxes are checked before signing on Page 2.

1. Acknowledgment of HIPAA Notice of Privacy Practices

I acknowledge that I have been provided access to the full Kairos Sleep Clinic Notice of Privacy Practices and Website Privacy Policy, which provide detailed descriptions of how my Protected Health Information (PHI) and digital data are used, disclosed, and protected. I understand I have the right to review these comprehensive terms prior to signing this document. Complete documents are hosted at kairossleepclinic.com/forms/privacy-policy.

☐ **I acknowledge receipt and have been given access to the Notice of Privacy Practices and Website Privacy Policy.**

2. General Consent for Treatment & Telehealth Operations

I hereby consent to medical evaluations, diagnostic procedures, sleep logging, testing, and treatments deemed necessary by my providers. I consent to receive care via secure telehealth platforms, understanding connection risks and limitations. I agree that I must be physically located within the State of Utah at the time of every telehealth encounter. In the event of a medical or mental health emergency, I agree to immediately call 911 or proceed to the nearest emergency room.

☐ **I consent to general treatment, emergency terms, and telehealth services under the clinical rules outlined above.**

3. Controlled Substance Policy & Clinical Guidelines

I understand that the clinical management of sleep disorders may occasionally involve the prescription of controlled substances (closely monitored wakefulness-promoting agents or sedative-hypnotics). I agree to abide strictly by the clinic's standard rules regarding compliance, single-provider sourcing, mandatory follow-up timelines, and strict refill restrictions. The full clinical guidelines are hosted at kairossleepclinic.com/forms/controlled-substance-policy.

☐ **I understand and agree to adhere to the comprehensive Controlled Substance Policy.**

4. Financial Policy, Insurance, & Identity Verification

I agree to provide a valid photo ID and insurance card. I accept full financial responsibility for all services rendered. Copays and deductibles are due at check-in and may be charged to a card on file (if applicable); otherwise, the clinic reserves the right to send a bill. I agree to the 24-hour cancellation policy ($50 fee). I understand that we refer to third parties (e.g. sleep studies) and bear no responsibility or liability for charges they levy; billing verification for referred services is my responsibility. Full terms are at kairossleepclinic.com/forms/financial-policy.

☐ **I accept financial responsibility, authorize identity verification, and agree to the 24-hour cancellation policy.**

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5. Optional Health Insurance & Billing Address Details

Health Insurance Provider:

Policy Number / Member ID:

Subscriber DOB (MM/DD/YYYY):

Subscriber Sex (M/F/Other):

Effective Date (e.g. Jan 1 - Dec 31):

Billing Address Line 1:

Billing Address Line 2 (Apt, Suite):

City:

State:

Zip Code:

Relationship to Insured (Self/Spouse/Child):

6. Electronic Signature & Attestation

By signing below, I certify that I have read, understood, and checked the acknowledgment boxes for the sections on Page 1. If representing the patient, I certify that I am the legal guardian/representative.

Patient / Representative Signature (Sign or Type Name):

Date:

Representative Printed Name:

Representative Relationship: