



ENT Medical Services Sleep Center, PLC
2901 Northgate Drive, Suite A
Iowa City, IA 52245

Freedom of Choice Statement

ENT Medical Services Sleep Center, PLC is required to provide information about your freedom of choice regarding the selection of the facility you have chosen for your sleep study.

I understand that I may choose where I get my sleep study. This has been explained to me. I understand that my doctor has partial ownership in the ENT Medical Services Sleep Center, PLC. I have freely chosen ENT Medical Services Sleep Center, PLC to perform my sleep study. I understand that, if needed, I may get sleep studies done at another facility. If I need my sleep study(s) or report(s) to take to another facility or doctor I understand that I will be required to sign a release of information and I will receive copies of the sleep study(s) and/or report(s).

I authorize the release of any medical or other information needed to process my claim with my insurance carrier, and request payment of benefits be made directly to ENT Medical Services Sleep Center, PLC, on my behalf.

Patient Name (please print): _____

Patient /Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____