



RAJIV M. JOSEPH, M.D., Ph.D., F.A.A.N.

NEUROLOGY & SLEEP MEDICINE

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A. CONSENT FOR TREATMENT

I acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.

Signature of Patient: _____

B. PATIENT INFORMATION

I have received information about my upcoming Sleep (polysomnography) Study. The potential diagnostic benefits of the study and the alternatives have been fully explained to me and I understand my options. I have received all of the information I wish and my questions have all been answered. I understand that I may refuse consent. ***I GIVE MY INFORMED AND VOLUNTARY CONSENT*** to the proposed diagnostic study, which will include:

1. Sensor application for measurement of sleep and breathing
2. Video recording to measure abnormal movements during sleep
3. Initiation of treatment for sleep disordered breathing

I understand that the alternatives to the proposed diagnostic study would be:

- A. To decline the study

Signature of Patient to proceed: _____

C. PARENT/GUARDIAN CONSENT

I voluntarily give my authorization and consent to the performance of a Sleep (polysomnography) Study. By signing below, I state that I am at least 18 years old or serve as legal guardian for a minor or an adult that is not legally competent to consent.

Signature of Patient: _____

D. CONFIDENTIALITY

I understand that any and all medical care that I receive at the office of Rajiv Joseph, MD, PA will be treated with the utmost confidentiality. However to facilitate my medical care I hereby authorize the office of Rajiv Joseph, MD, PA to provide information about my treatment and medical condition to the following.

Name/ relationship _____

Name/ relationship _____

**Please provide our office with 48 hours notice if you must cancel your test or you may be subject to a \$100.00 cancellation fee.*

Signature of Patient: _____ **Date:** _____

Witness _____ **Date** _____