Apnea Link Plus Overnight Evaluation Patient Liability Form

I acknowledge that I was loaned a Home Sleep Testing Device from BayCare Health Systems Sleep Disorders Department and agree to return the Equipment by the date specified on the form included with the product.

I further acknowledge that in the event I fail to return the Equipment within the specified time noted on the form included with the equipment, I will be billed in the amount of **One Thousand Five Hundred Dollars** ($1500.00) for the purchase of the Equipment.

Patient Name: _____

Patient Signature: _____

Date: _____