

# TERMS AND CONDITIONS OF SERVICE & RENTAL AGREEMENT

**Effective Date:** January 25, 2026

**Equipment Provider:** Charlotte Sleep Solutions

**Sleep Medicine Provider:** iSleep Physicians

## 1. PROGRAM OVERVIEW & NATURE OF SERVICES

By enrolling in this Home Sleep Test (HST) program, you ("Patient") agree to the following structural understanding of the services provided. You acknowledge that this program involves two distinct and separate entities working in partnership:

- **Charlotte Sleep (The Equipment Provider):** We are a Durable Medical Equipment (DME) company. We provide the logistics, the *SleepImage Ring* device, and any other sleep testing device and equipment for the home sleep test and sleep software reporting. We do not diagnose sleep disorders. After the sleep physician has diagnosed you, the patient, we follow their instructions in rendering treatment.
- **iSleep Physicians (The Medical Team):** This is an independent group of Board-Certified Sleep Physicians. They are solely responsible for your Telehealth consultations, the interpretation of your sleep data, and your medical diagnosis/prescription.

**North Carolina Regulatory Notice:** You acknowledge that Charlotte Sleep Solutions has performed a *preliminary screening* only. A dentist in North Carolina cannot legally diagnose Obstructive Sleep Apnea (OSA). This diagnosis can only be made by a licensed Medical Doctor (MD/DO). By signing this, you consent to establishing a doctor-patient relationship with iSleep Physicians for diagnosis purposes.

## 2. SERVICE OPTIONS & FINANCIAL RESPONSIBILITY

You have selected one of the following payment tracks. You acknowledge that authorization for the rental does not guarantee insurance coverage.

### Option A: Self-Pay / Cash Package (Recommended)

- **Total Cost: \$429.00** (Upfront, All-Inclusive).
- **Includes:** 7-Day Device Rental, Pre-test & Post-test Telehealth visits with iSleep Physicians, Data Interpretation, and Diagnosis/Prescription.
- **Timeline:** Fastest option (results typically within 2 weeks).

### Option B: Commercial Insurance

- **Upfront Cost: \$270.00** (Patient Fee for 7-Day Device Rental).
- **Billable Services:** The two (2) Telehealth visits will be billed to your medical insurance by iSleep Physicians.
- **Patient Responsibility:** You are responsible for any copays, coinsurance, or deductibles associated with these visits. If your insurance denies the claim for any reason (including "medical necessity" or "out of network"), you are responsible for the provider's standard rates.

## 3. EQUIPMENT RENTAL AGREEMENT & LIABILITY

**Sleep Test Device:** SleepImage Ring (FDA-Cleared Home Sleep Testing Device) **Serial Number:** Recorded on file upon shipment/pickup.

You agree to rent the SleepImage Ring under the following strict liability terms:

1. **Care & Custody:** You assume full responsibility for the device, charging cord, and case while they are in your possession.
2. **Wrongful Use:** Any use of the device outside of the provided instructions is considered a breach of this agreement and renders you liable for the full replacement cost.
3. **Sleep Test Device Return Policy:**
  - **Deadline:** The device must be returned (or postmarked) by the agreed-upon date specified in your rental confirmation ("Return the Ring Device by 5pm on [Date]").
  - **Late Fees:** Failure to return the device by the deadline will result in a **daily late fee of \$83.00**.

- **Replacement Cost:** This daily fee will continue for up to four (4) days. After 4 days, the device is considered "lost/stolen," and you are liable for the full **Replacement Cost of \$332.00**.
4. **Authorization to Charge:** You explicitly authorize Charlotte Sleep to charge the credit card on file for any late fees or the full replacement cost (\$332) if the device is not returned within the specified timeframe.

#### 4. DEVICE USAGE & COMMUNICATION PROTOCOL

##### Communication is Everything.

- **24-Hour Notice:** If you experience *any* technical issues, difficulty syncing the device and app, or comfort issue, you must communicate this to Charlotte Sleep within **24 hours** of first noticing the issue.
- **No "Do-Overs":** If you fail to capture data because of user error or technical issues and *do not* report it within 24 hours, you may be responsible for a re-rental fee to rent the device beyond 1 week.
- **Instructions:** You agree to use the SleepImage Ring solely according to the directions provided during your intake and Telehealth session.

#### 5. SHIPPING & LOGISTICS

- **Pickup:** You may pick up the device in person at our Charlotte office at no additional cost.
- **Shipping:** If you select shipping, a **\$57.00** fee applies, which includes delivery to you and a prepaid return label.

#### 6. TELEHEALTH CONSENT

1. **Telehealth Limitations:** You understand that Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care.
2. **Eligibility Assessment:** You acknowledge that the online "Home Sleep Test Eligibility Quiz" you may have taken is a non-clinical pre-assessment tool. It does *not* constitute a medical diagnosis and does not replace the professional judgment of the iSleep Physician.

#### 7. DATA SHARING AUTHORIZATION

To ensure continuity of care with your referring provider (e.g., your Dentist), you hereby authorize the release of your sleep study raw data, results, and the iSleep Physician's diagnostic report to:

1. iSleep Physicians for interpretation.
2. Charlotte Sleep for records, device processing and treatment, such as Oral Appliance Therapy.

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#### 8. PATIENT ACKNOWLEDGEMENT

##### By signing below, I attest that:

- I understand Charlotte Sleep is a logistics provider, not a medical practice.
- I understand the **\$332 replacement liability** and the **\$83/day late fee**.
- I authorize Charlotte Sleep and iSleep Physicians to share my medical findings with my referring provider to facilitate treatment.
- I have read and agree to the terms above.

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Signature of Patient/Responsible Party

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Date

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Printed Name of Patient/Responsible Party