REGISTRATION FORM # 4

IF YOU HAVE FILLED THIS OUT PREVIOUSLY AND NOTHING HAS CHANGED, PLEASE WRITE "SAME"

Name: _____ Sex: M F Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Marital Status: _____ Driver License: _____ State: _____
Emergency Contact: _____ Emergency Contact Phone: _____
Employer: _____ Referring Physician: _____
Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ Insurance Phone: _____
Name of Insured: _____ ID# _____ Group: _____
Date of Birth: _____ Employer: _____ Relationship to Patient: _____
Secondary Insurance: _____ Insurance Phone: _____
Name of Insured: _____ ID# _____ Group: _____
Date of Birth: _____ Employer: _____ Relationship to Patient: _____

PRIVACY PRACTICES

I have read the Notice of Privacy Practices. I understand that if I have questions or complaints I may contact the Facility's Clinical Director or Administrator.

List the names of any person (such as spouse, son /daughter, friend etc..) you give permission for us to speak to:

Name(s):	Relationship to you:
_____	_____
_____	_____
_____	_____

Please Initial _____

TRANSFER OF RIGHTS

I, _____ Transfer rights to Sleep Diagnostics of America, Inc. to act on my behalf with respect to any claims filed to my insurance company, including peer to peer reviews, reconsiderations, appeal, hearings (IRO & ALJ) and complaints. **Please Initial _____**

NO SHOW POLICY

We require a notice of at least 48 hours of any rescheduling or canceling of an appointment. If we are not given 48-hour notice you will be billed a fee of $150.00 which is not covered by insurance. Some of our patients are dealing with serious sleep disorders and you could be taking a place of someone else. Thank you

PATIENT'S SIGNATURE: _____ **DATE: _____**

Rev. 03.18

SLEEP HISTORY QUESTIONNAIRE - #14 on checklist

Date: _____

Patient: _____ **DOB:** _____ **Age:** _____ **Height:** _____ **Weight:** _____

Epworth Sleepiness Scale – Please rate the chance of dozing in the following situations:

0-Would never doze **1-Slight chance of dozing** **2-Moderate chance of dozing** **3-High chance of dozing**

Situation:		
	Sitting and reading	_____
	Watching TV	_____
	Sitting inactive in a public place (e.g. theater or meeting)	_____
	As a passenger in a car for an hour without a break	_____
	Lying down to rest in the afternoon when circumstances permit	_____
	Sitting and talking to someone	_____
	Sitting quietly after lunch without alcohol	_____
	In a car, while stopped for a few minutes in traffic	_____
		_____ **Total**

MEDICAL HISTORY

Please check below if you have or have had any of the following (even if being treated with medication):

Allergies	☐	Scoliosis	☐
Asthma	☐	Seizures	☐
Diabetes	☐	Swelling of Hands and/or Feet	☐
High Blood Pressure	☐	Heart Problems	☐
Laser Surgery for Snoring	☐	Heart Attack /Stroke	☐
Nasal Surgery	☐	**C**hronic **O**bstructive **P**ulmonary **D**isease **(COPD)**	☐
Multiple Sclerosis	☐	**C**ongestive **H**eart **F**ailure **(CHF)**	☐
Nocturnal Esophageal Reflux / GERD	☐	**C**oronary **A**rtery **D**isease **(CAD)**	☐
		Periodic **L**imb **M**ovement **D**isorder **(PLMD)**	☐
Parkinson's	☐	**R**estless **L**eg **S**yndrome **(RLS)**	☐

Are you currently on supplemental oxygen? ☐ NO

☐ YES @ _____ lpm and I use it for ☐ DAY ☐ NIGHT ☐ DAY AND NIGHT

MEDICAL HISTORY

Weight: Have you had a recent weight gain or loss? ☐ Gain _____lbs. ☐Loss - _____lbs.

In what length of time: _____ yr. _____ mo.

List medications:	**Dosage/Time**:	**Reason for medication:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

****if additional room is needed to list medications, please continue on the back of this form**

Patient: _____

SLEEP HISTORY, part 2

Please check all that apply - currently or in the past (whether frequently or infrequently)

- ☐ I sleep in a bed
- ☐ I share the bed with a partner
- ☐ I sleep in a recliner
- ☐ I watch TV while in bed
- ☐ I sleep on my - ☐ back ☐ stomach ☐ R-side ☐ L-side
- ☐ I snore – ☐ light ☐ moderate ☐ loud
- ☐ I have trouble sleeping on my back
- ☐ I have trouble breathing through my nose
- ☐ I stop breathing while sleeping
- ☐ I have choking sensations while sleeping
- ☐ I gasp for air while sleeping
- ☐ I awaken with dry mouth
- ☐ I talk in my sleep
- ☐ I walk in my sleep
- ☐ I often toss and turn
- ☐ I grind my teeth
- ☐ I have vivid dreams while falling asleep
- ☐ I have night sweats
- ☐ I have night terrors
- ☐ I awaken frequently during the night
- ☐ I often wake up to urinate
- ☐ I awaken with headaches
- ☐ My pets sleep in my bedroom
- ☐ I have gas, indigestion, or heartburn
- ☐ I have PLMD (periodic limb movement-arms or legs jerk, twitch)
- ☐ I have restless legs (tingling, itchy, creepy-crawling sensations)
- ☐ I feel paralyzed/unable to move when I wake up
- ☐ I feel sleepy during the day
- ☐ I have to fight bouts of sleep during the day
- ☐ I have to fight bouts of sleep while driving
- ☐ I have a lack of concentration/focus
- ☐ I have trouble remembering things
- ☐ I am often irritable
- ☐ I have been in a wreck due to sleepiness
- ☐ I have feelings of depression
- ☐ I have anxiety
- ☐ I have a lack of sexual drive
- ☐ I have problems with impotence
- ☐ I have Post Traumatic Stress Disorder (PTSD)
- ☐ I have been told I bang my head while sleeping
- ☐ My knees buckle/get weak when I am startled, or when laughing
- ☐ I am under the care of a Cardiologist
- ☐ I use supplement oxygen

Other medical problems not listed:

_____

_____

_____

Patient: _____

RECENT ILLNESS

Have you recently suffered or currently suffering from a respiratory infection, flu, or cold? No Yes

List Allergies: ☐ Seasonal allergies ☐ Sinus Problems ☐ No Known Allergies

_____

Surgeries (list below)	**Year**	**Surgeries (list below)**	**Year**
_____	_____	_____	_____
_____	_____	_____	_____

Sleep concerns/problems: What type of sleep problems do you have? How long have you had sleep problems?

_____

_____

_____

SOCIAL HISTORY

What is your present occupation: _____ Hours worked: _____

Are you a shift worker: _____ Do you drive a vehicle for work: _____

Do you smoke: _____ If yes, how many years: _____ How many packs/day: _____ Have you quit: _____

Do you drink caffeinated beverages: _____ How many times per day: _____

Do you drink alcoholic beverages: _____ How often during week: _____ On weekend: _____

Do you exercise regularly: _____ If yes, how often: _____

Do you have unusual eating habits? _____ If yes, please explain: _____

SLEEP HISTORY, part 1	**On weekdays**	**On weekends**
What is your usual – bed time	_____	_____
What is your usual – wake time	_____	_____
If you take naps, how many?	_____	_____
If you take naps, for how long?	_____	_____
How long does it take you to fall asleep?	_____	_____
Do you awaken feeling refreshed?	_____	_____

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES AND REQUEST FOR E-COMMUNICATIONS

#7 on checklist

This document contains Acknowledgement: Receipt of Notice of Privacy Practices as required under the privacy standards issued by the United States Department of Health and Human Services, pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as updated by the 2013 HIPAA Final Omnibus Rule. Also, there is a request to communicate via electronic methods such as email, or text. If you understand the risk involved (someone gaining access to communications) and you would like for our office to communicate via text or email, please review, fill in the info. and sign the form. If you do not want any communication via electronic method then please leave that section blank. Form is on the back of this.

According to the Federal Register Response to Public Comments: "Providers are only required to give a copy of the Notice of Privacy Practices to, and obtain a good faith acknowledgement of receipt from, new patients." This means that for current patients, a practice need only make the Notice available upon request after the effective date of its revision and promptly post the Notice in a clear and prominent location.

PLEASE READ YOUR COPY OF OUR PRIVACY PRACTICES AND SIGN THE FORM ON BACK AND RETURN TO STAFF MEMBER

REQUEST FOR ELECTRONIC COMMUNICATIONS

Patient Name: _____

I request that the following method(s) of communications from the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the practice responsible should such incident occur.

Communications: ☐ Appointment reminders ☐ Other: _____

Method:

☐ E-mail E-mail address: _____

☐ Text Phone Number: _____

Time period for this method: _____

Acknowledgement and Agreements: I understand and agree that the requested communication method is not secure, making my PHI at risk for receipt by unauthorized individuals. I accept the risk and not retaliate against the practice in any way should this occur.

Signed: _____ Date: _____

Printed name: _____ Phone #:_____

Address: _____

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Sleep Diagnostics of America's Notice of Privacy Practices effective 9/23/13.
Please specify any requests, such as a specific communication (not to leave a message for you at work) or if you request we use one specific phone number to reach you, please specify. (if no requests, leave blank)

_____

_____

Signature: _____ Date: _____
(patient) please sign

This section is for PARENT OR GUARDIAN ONLY

I am a parent or legal guardian of _____ (patient name). I have received a copy of Sleep Diagnostics of America Notice of Privacy Practices

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: _____

Main Office: 17300 Saturn Ln # 113
Houston, TX 77058
Phone 281.218.6990

INFORMATION AND CONSENT FORM - # 2 on checklist

SLEEP STUDIES

The purpose of an overnight sleep study is to document any respiratory, neurological, cardiac, or physical dysfunction that may occur during sleep. After the Interpreting physician reviews the data, he will determine the presence or absence of a sleep disorder. The results will be given to the ordering physician. In preparation for the sleep study the sleep tech will attach monitoring electrodes to various areas of your body using a special paste. This paste adheres securely but is dissolved at the end of the test. All other electrodes will be attached to your skin with hypoallergenic tape. The Sleep Tech will go over instructions and the general aspects of the test and answer questions you may have. Some questions may not be able to be answered, but you can call the administrative office for any questions that cannot be answered by the Sleep Tech.

Respiratory efforts are monitored by stretch belts applied around the chest and abdomen, Oxygen in the blood is monitored by attaching a finger probe to your index finger called pulse oximetry. There is no pain in this evaluation (no needles etc.)

This test can also be used to diagnose OSA (obstructive sleep apnea). A condition that causes the person to stop breathing during sleep. The obstruction can be caused by any number of factors such as: oversized uvula, tongue blocking airway, nasal obstruction, recessed chin, excess tissue in neck area, etc. There are other medical conditions, or sleep disorders that can be evaluated using these devices as well. After all the electrodes are attached, they are plugged into a small device that has a lanyard (easy to take with you to rest room) it is connected through software which is collecting data throughout the night. An audio/video recording of the night is also part of your study. Any time you need to get up during the night **will not** compromise the evaluation, so don't worry. ☺ Many patients worry about this.

The Sleep Tech is responsible for more than one patient, so if you do not get a response from someone, call out again until the technician comes in to assist you.

PLEASE DO NOT TRY TO GET OUT OF BED YOURSELF

If you are diagnosed with OSA (obstructive sleep apnea) you and your physician will be informed when the test results are available, and you may be scheduled for the treatment test using CPAP (continuous positive airway pressure) if your doctor has ordered it. The administrative office staff will guide you through everything, they will contact you with results and let you know what needs to be done.

If you are scheduled for an MSLT (multiple sleep latency test)

It is a daytime evaluation in conjunction with the nighttime test you will be awakened approximately 7 hours after the lights are turned out. After completing your nighttime test you will remain in the center and we provide breakfast and lunch (without caffeine) unless you have decided to bring your own meals. Throughout the daytime evaluation which consists of a series of "naps" it usually lasts until anywhere from 3pm -5pm. An MSLT will measure your daytime sleepiness and rules out other sleep disorders such as Narcolepsy. You would have been made aware of this test ahead of time if it was ordered since special arrangements must be made.

CONSENT

I, (Print Name) _____, have read the explanation for the sleep study and understand the procedures and I also understand that if I should get out of bed without assistance that I could injure myself or damage lab equipment. I voluntarily give my informed consent to have Sleep Diagnostics of America provide an attended sleep study which could include but is not limited to npsg, npsg with cpap, hst, split, bpap titration, mwt, or mslt (if ordered) and performed for purposes of determining future treatment by my physician.

PATIENT SIGNATURE: _____ **DATE:** _____

Assignment of Benefits

- I hereby authorize direct payment(s) be made to **Sleep Diagnostics of America ("SDOA")** or any of their affiliates from my insurance benefits payable on my behalf for all services provided to me by SDOA or their affiliates. (e.g. affiliates include but is not limited to LWC Institute, TWC, Dr. Burkes, Dr. Share, Homelink, or other third party). "Services" includes any and all services provided, such as attended sleep testing, unattended sleep testing, evaluations, consults, rendering medical equipment, supplies, compliance and more. It is agreed that payment to Sleep Diagnostics of America or their affiliate by a medical insurance company shall discharge the insurance company of any obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment and that all amounts are due upon request.
- We want you to know what happens in the event a procedure processes out of network. There are many different types of plans from Insurance companies. If your insurance processed claim out of network, I can assure you that we will appeal and work hard to get them to pay. If they do not pay and you receive a bill, do not worry – call us and we will go over all options. We are here for you.
- This assignment will remain in effect until revoked by me in writing.
- I hereby authorize said assignee to release all information necessary to secure payment.
- A photocopy of this assignment is to be considered as valid as an original.

Authorization for Release of Information/Health Care Information

- I authorize SDOA and/or their affiliate(s) including the physician(s) involved in my care to release medical information and supporting documentation compiled in my medical records to the payor responsible for reimbursement (e.g.: insurance company, or other payor requesting records)
- I acknowledge that data collected from my patient record will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, sleep techs, durable medical equipment provider, and other health care agencies involved in my care during and after services rendered by Sleep Diagnostics of America and/or their affiliates.
- I further acknowledge that my medical records may be utilized in the sleep labs performance improvement, quality assurance, peer review, and other similar processes of studies. I also acknowledge that my medical records will also be made available to governmental agencies as required by law.
- I authorize the release of my identification, (e.g.: social security number) in accordance with federal law and regulations to the manufacturer of any medical device I receive in order to meet their guidelines and requirements for the class 2 medical device.

Notice of Separate Billing:

- I hereby acknowledge that sleep study interpretation (test results) may be billed separately from the facility my testing was performed at.

I hereby certify and state that I have read, and that I fully and completely understand this Authorization for Release of Information /Health Care Information and Assignment of Benefits, and that I have signed this Authorization for Release of Information and Assignment of Benefits, knowingly, freely, and voluntarily.

_____ _____/_____/_____

Patient's Signature Date

_____ _____ _____/_____/_____

Witness Relationship Date

*If the patient is unable to sign, express consent, or is a minor, please complete the following:

_____ Patient's condition is such that he/she is unable to sign.

Explain:_____

_____ Patient is a minor, _____ years of age.

_____ _____ _____/_____/_____

Signature of closest relative Insured/Relationship Date

_____ _____ _____/_____/_____

Witness Relationship Date

PATIENT RIGHTS & RESPONSIBILITIES - # 5 on checklist

PATIENT RIGHTS:

1. The patient has the right to considerate and respectful service
2. The patient has the right to obtain service without regard to race, creed, national origin, sex, age, disability, diagnosis or religious affiliation
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical information. Individuals or organizations not involved in the patient's care may not have access to the information without the patients' written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear or termination of service or other reprisal in the service process.

PATIENT RESPONSIBILITIES:

1. The patient should promptly notify the company of any wrongful service.
2. The patient can be responsible for any equipment damaged or missing from sleep study.
3. The patient should promptly notify the sleep lab of any changes to their address or telephone.
4. The patient should promptly notify the sleep lab of any changes concerning their physician.
5. The patient should notify the sleep lab of discontinuance of service.

PROTOCOL FOR RESOLVING COMPLAINTS FROM BENEFICIARIES

* The patient has the right to freely voice grievances and recommend changes in care of services without fear of reprisal or unreasonable interruption of services.
* Service, equipment, and billing complaints will be communicated to management and upper management.
* These complaints will be documented in the Complaint Log, and completed forms will include the patient's address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint. All complaints will be handled in a professional manner.
* All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified and patient will receive written notification within 14 days.
* Questions or complaints, please contact (281)-218-6990, Monday through Friday from 9:00AM-5:00PM closed for lunch 12-1pm

PATIENT SIGNATURE OF RECEIPT: _____ DATE: _____