Dr. Alexander A. Clerk's Office
O'Connor Health Center 1
455 O'Connor Drive,
Suite 110,
San Jose, CA. 95128

Main: 408.295.4532
Fax: 408.295.4738
Email: info@sleepmedicineservice.com
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Consent for Treatment

Sleep Disorders Clinic

Patient Name:

Date of Birth (MM/DD/YY): ___ / ___ /_____ **Medical Record #**

For purposes of this document, Sleep Medicine Services shall refer to and mean, individually and collectively, the clinic, including but not limited to emergency and all other services.

1. General Medical Consent. The undersigned hereby consents to procedures, which may be performed during this clinic visit, rendered under the general and special instructions of patient's attending physician.

2. Nursing Care. Clinic does not provide. However, if the patient's condition is such as to need the service of a private or special duty nurse, it shall be understood that the patient or the patient's legal representative at the patient's expense must arrange this. The Clinic shall in no way be responsible for failure to provide a private or special duty nurse and is hereby released from any and all liability rising from the fact that the patient is not provided with such additional care.

3. Legal Relationship between Clinic and Physician. Except for those physicians under contract with Sleep Medicine Services, all physicians and surgeons furnishing service to patient, including the radiologist pathologist, anesthesiologist, and the like, are independent contractors with the patient and are not employees or agents of Sleep Medicine Services. It is understood that the patient is under the care and supervision of his or her attending physician and that it is the responsibility of Sleep Medicine Service and health care staff to carry out the instructions of such physician or surgeon. At the request of the attending physician, Allied Health Professionals may participate in patient care. It is the responsibility of patient's physician or surgeon to obtain the patient's informed consent, when required for medical or surgical treatment, special diagnostic or therapeutic procedures, or clinical service rendered to patient under the general and special instructions for the physician or surgeon.

Statement of Financial Responsibility

4. Financial Agreement. In consideration of the service to be rendered to the patient, the undersigned agrees to accept full responsibility for the patient's account in accordance with the regular rates and terms of Sleep Medicine Services. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. The undersigned further authorizes the transfer of any patient credit balance from one account to another account opened for the same patient, e.g., from mother's account to her newborns account.

5. Assignment of Insurance Benefits.

(a) To the degree permitted under applicable insurance policy, health care service plan or third party pay or agreement ("insurance"), the patient hereby irrevocably assigns to Sleep Medicine Services any and all rights and interest in insurance proceeds, benefits or policy provisions payable to or on behalf of the patient. The patient directs all insurance companies, health care service plans and other third party payors ("payors") to make payment on patient's behalf directly to Sleep Medicine Services. Charges for services rendered shall be at a rate not to exceed the ("payors") regular charges unless otherwise agreed in writing by Sleep Medicine Services or as required by law.

(b) The patient has primary financial responsibility for all patient-related Sleep Medicine Services charges even if Sleep Medicine Services agrees to accept payment directly from the responsible payors, except as otherwise provided under applicable law or regulation.

(c) The patient shall remain responsible for the payment of all unpaid amounts and for all services provided to patient which are not covered services under the relevant insurance.

6. Health Care Service Plan Obligations. Sleep Medicine Services maintains a list of health care service plans with which it contracts. A list of such plans is available upon request from the financial office. Sleep Medicine Services has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to patient by Sleep Medicine Services if not approved, paid or covered by health care service plan.

7. Medicare Certification, Authorization to Release Information and Payment Request. The undersigned certifies that the information given by patient in applying for payment under Title XV11 of the Social Security Act (Medicare) is correct. The undersigned authorizes any holder of medical or other information about patient to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or the Peer Review Organizations, any information needed for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on patient's behalf. The undersigned authorizes the Social Security Administration to release information/records about Medicare benefits to Sleep Medicine Services for the purpose of Medicare benefits confirmation only.

8. **NOTICE OF PRIVACY PRACTICES (USES AND DISCLOSURES OF HEALTH INFORMATION)**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, o domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose your health information to military authorities of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

9. Personal Property. SLEEP MEDICINE SERVICES DOES NOT ASSUME RESPONSIBILITY FOR PERSONAL PROPERTY. IT IS THE POLICY OF SLEEP MEDICINE SERVICES TO RECOMMEND THAT PATIENT SHOULD KEEP NO MORE THAN $200 ON HIS OR HER PERSON DURING PATIENT' CLINIC STAY. ANY MONEY OR PERSONAL PROPERTY VALUED AT MORE THAN $200 SHOULD BE SENT HOME WITH FAMILY MEMBERS. The liability of Sleep Medicine Services for lost personal property, which is deposited with Sleep Medicine Services for safekeeping, is limited by statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from Sleep Medicine Services by the patient.

10. Unclaimed valuables remaining greater than one calendar year from the date of discharge will be disposed of at the discretion of Sleep Medicine Services.

The undersigned certifies that he/she has read the forgoing, received a copy thereof, is the patient and agrees to accept the terms and provision of this document

Patient Signature: _____

Date: _____ Time _____ am pm

The undersigned agrees to accept financial responsibility for services rendered to the patient and to accept the terms and provision of this document.

Responsible Party Signature (other than patient) / Guarantor: _____

Relationship: _____

Witness Signature: _____

Date: _____ Time _____ am pm

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Sleep Disorders Clinic

Clinic Confidential Patient Information

Patient Information			
Patient's Name:			
Date of Birth: (MM/DD/YYYY): / /	Social Security #: - -	Sex: ☐ Male | ☐ Female	
Home Address:			
Home #: ( ) -	Work#: ( ) -	Cell # ( ) -	
Email:	Pharmacy Name:	Contact # ( ) -	
EMERGENCY CONTACT:	Relationship:	Contact # ( ) -	
☐Retired | ☐Self Employed | ☐Employed	Employer Name:		
Work Address:			
Education:	☐ Grade School | ☐ High School | ☐ College | ☐ Postgrad | ☐ Graduate School		
Marital Status:	☐ Minor | ☐ Single | ☐ Married | ☐ Widowed | ☐ Separated | ☐ Divorced | ☐ Cohabitating		
Ethnicity/Race	☐ Decline | ☐ Caucasian | ☐ African American | ☐ Asian American | ☐ Native American | ☐ Hispanic ☐ Other Hispanic		
Do you smoke cigarettes?	☐ No | ☐ Yes	If Yes, how many packs a day?	
Current Medications List: ☐ N/A Please list all medications with dosage amount.			

Insurance Information			
Primary Insurance:	☐ HMO ☐ PPO ☐ Other	Subscriber ID:	
☐ Same as Above Subscriber Name:	Group #:	Date of Birth: / /	
Claims Address:		Contact # ( ) -	
Secondary Insurance:	☐ HMO ☐ PPO ☐ Other	Subscriber ID:	
☐ Same as Primary Subscriber Name:	Group #:	Date of Birth: / /	
Claims Address:		Contact # ( ) -	

Guarantor/Responsible Party		
☐ Same as Above Guarantor's Name:	Guarantor's Social Security #: - -	
Home Address:	Contact #: ( ) -	

Referring Physician/Primary Care		
Referring Physician:		
Mailing Address:		
Main #: ( ) -	Fax #: ( ) -	May we consult this physician? ☐ Yes | ☐ No

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The Epworth Sleepiness Scale (ESS)

Sleep Disorders Clinic

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

POSIBLE SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching television	
Sitting inactive in a public place (*e.g. a 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 a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	0

SCORE RESULTS:

1-6	**Congratulations, you are getting enough sleep!**
7-8	Your score is average
9 +	Very sleepy and should seek medical advice

Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep*, *14*, 540-545.

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Sleep Evaluation

Sleep Disorders Clinic

Name: Date:

Age: Height: Weight: Sex: ☐Male ☐Female

1. My Chief Compliant is?

2. List Past Illnesses: ☐None

3. List Past Surgeries: ☐None

4. Current Medications: ☐None

5. Medications Allergies: ☐None

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Sleep Evaluation

6. Social History

Do you have Children? ☐No ☐Yes - If yes how many? _____

Do you exercise? ☐No ☐Yes - If yes please describe type: _____

Describe your Diet: ☐Average ☐Vegetarian ☐Poor

Do you Smoke? ☐No ☐Yes - If yes how many pack a day: _____

Do you use Alcohol? ☐No ☐Yes

Do you use any Recreational Drugs? ☐No ☐Yes

7. Family History

(List any medical condition(s) the following family member have or may have had)

Mother's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Father's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Sibling's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____

Other Family Member's Name:_____

Date of Birth:_____

Medical Conditions:

_____

_____