



Terms and Conditions of Service

Name: _____ Birth Date: _____

Account No. _____ Medical Record No. _____

Consent for Treatment

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 XVI 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 benefit 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 you 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 you health information for marketing communications without your written authorization.

Required by Law: 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, or 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 authorized 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.

Responsible Party

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 _____

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



Clinic Confidential Patient Information *(Please fill out both sides of the form)*

SMS # (FOR CLINIC USE): Appointment Date: ____/____/____ Time: ____:____ am/pm

Patient Name: _____
Last First M.I. Maiden Name

Patient Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Birth Date: _____ Sex: ____ F ____ M Fax: _____

Social Security #: _____ - _____ - _____

Temporary Address *(If from out of state or country):*

Street: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Employer : _____

Employer's Address: _____ Patient's Occupation: _____

City: _____ State: ____ ZIP: _____ Phone: _____ Fax: _____

Background Information

Education *(Please circle highest level completed):*

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 more
(Grade School) (High school) (College) (Post Graduate)

Ethnic Origin: Caucasian Native American African American Puerto Rican

Mexican American Other Hispanic Asian American Other _____

Household Status *(circle one):* Single Married Widowed Divorced Separated Cohabiting Other

Do you smoke cigarettes? ____ Yes ____ No

If yes how many packs per day? _____

Medications you are now taking *(including dosage in mg / day):* _____

Deposit/Copayment: \$ _____ (due at time of visit) or \$ _____ if insurance not contracted with Sleep Medicine Services.

Init. _____

Emergency Contact

Name: _____ Relationship to Patient _____

Address: _____

City: _____ State: _____ ZIP _____ Home Phone: _____ Work Phone _____

Guarantor (person responsible for payment/insurance)

Name: _____ Relationship to Patient: _____

Address: _____ Date of Birth: _____ / _____ / _____

City: _____ State: _____ ZIP: _____ Social Security #: _____ - _____ - _____

Home Phone: _____ Work Phone: _____ ext. _____

Employer: _____ Address: _____

Insurance Information

Primary Insurance Company:

Secondary Insurance Company:

Name: _____

Name: _____

ID#: _____

ID#: _____

Group: _____

Group: _____

Billing Address: _____

Billing Address: _____

Phone #: _____

Phone #: _____

Effective Date: _____

Effective Date: _____

Worker's Compensation:

Case #: _____ ID#: _____

Billing Address: _____ Phone #: _____ Date of Injury: _____

Referring or Primary Care Physician (PLEASE NOTE— if you do not provide physician information your reports will not be sent out to your physician/s)

Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ May we consult with this physician? _____ Yes _____ No



The Epworth Sleepiness Scale

Name: _____ Date: _____ Age: _____ Sex: M ___ F ___

My chief complaint is: _____

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 effected 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

Situation

Chance of Dozing

Sitting and reading

Watching TV

Sitting, inactive in a public place (e.g. a theater or a meeting)

As a passenger in a car for an hour without a break

Lying down to rest in the afternoon when the circumstances permit

Sitting and talking to someone

Sitting quietly after a lunch without alcohol

In a car, while stopped for a few minutes in traffic

Thank you for your cooperation



Sleep Evaluation

Name: _____ Date: _____ Age: _____

Neck Size: _____ Height: _____ Weight: _____ Sex: M _____ F _____

My chief complaint is: _____

Please check the appropriate answer:

1. Do you snore? Yes No I don't know

If "yes" please continue with question 2. If "no" or "I don't know" please skip to question 6.

2. Your snoring is: Softer than talking As loud as talking Louder than talking

3. Your snoring occurs: every/almost every night A few times a week Once or less a week

4. Your snoring is: Frequently interrupted by pauses or choking Occasionally interrupted by pauses or choking

Not interrupted as far as I know

5. Do you snore in every body position? Yes No I don't know

6. Do you have, or have you ever had a bed partner: Yes No

If "yes" please continue with question 7. If "no" please skip to question 10.

7. Has your bed partner ever said that you have pauses in your breathing or periods of stopped breathing during your sleep?

Yes No

8. Has your bed partner ever commented that you snore? Yes, loud snoring Yes, soft snoring No

9. If you snore, is it loud enough to bother her/him? Yes No

10. Has anyone besides a bed partner ever commented on your snoring (roommate, neighbor, family, etc.)

Yes (loud) Yes (soft) No

11. Do you feel fatigued, exhausted, tired or not up to par?

3 or 4 times a day

Nearly every day

Once or twice a week

Once or twice a month

Never or hardly ever

12. Do you feel that in some way your sleep is not refreshing or restful?

- 3 or 4 times a day
- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

13. Do you have periods of the day when you have trouble paying attention, remembering things or staying awake?

- 3 or 4 times a day
- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

14. Do you wake up during the night or in the morning with headaches? Yes No

15. When falling asleep or waking up do you feel paralyzed? Yes No

16. Do you dream or hallucinate as you fall asleep? Yes No

17. Do you feel weakness in response to anger, laughter or surprise? Yes No

18. Are you a shift worker? Yes No

19. Do you have trouble initiating and/or maintaining sleep?

- 3 or 4 times a day
- Nearly every day
- Once or twice a week
- Once or twice a month
- Never or hardly ever

20. What do you feel is your ideal amount of sleep per day? 2-3 hrs 5 6 7 8 9 10+

21. Estimate the average number of hours of sleep you have per day. 2-3 hrs 5 6 7 8 9 10+

Answer by circling a number from 1 to 5. If you strongly disagree with the statement or it never happens to you circle 1. If the statement is always true in your case or you agree strongly with it circle 5. You may also choose 2 (rarely), 3 (sometimes), or 4 (usually) as the answer.

22. When falling asleep, I feel paralyzed (unable to move) 1 2 3 4 5

23. I get too little sleep at night 1 2 3 4 5

24. I often have a poor night's sleep 1 2 3 4 5

25. I have trouble getting to sleep at night 1 2 3 4 5

26. I wake up often during the night 1 2 3 4 5

27. My bedtime varies a lot 1 2 3 4 5

28. At bedtime, thoughts race through my mind 1 2 3 4 5

29. At bedtime, I feel sad and depressed 1 2 3 4 5

30. At bedtime, I worry about things 1 2 3 4 5

Previous illnesses:

Name of illness

Year of onset

Name of illness	Year of onset

Beck Inventory: *Read each item below carefully and circle the number next to the answer that best describes how you have been feeling the past few days.*

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't even cry even though I want to.
11. 0 I am no more irritated by things than I ever am.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time now.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.
14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.
15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get tired more than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.
20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches or pains, or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

I was initially motivated to come to this clinic by my

Physician

Myself

Family member

Friend

Other comments (spouse) _____