Sleep Management Services

SLEEP STUDY CONSENT FORM

Patient Name: _____ Study Ordered: _____

- My physician has informed me that I need a sleep study performed, in the interest of my health and proper medical care.
- My physician/technologist has explained the testing to be performed.
- My physician/technologist has explained to me that I may need nasal CPAP (Continuous Positive Airway Pressure) therapy during the sleep study.
- I have had the opportunity to ask questions, and I consent to the sleep study.
- I understand that I will be monitored by camera throughout testing.
- Only with your written consent can we release information about your medical condition to a family member, please list family members and their relationship to you that you authorize the release of medical information.

  _____

  _____
- I authorize Sleep Management Services to release medical information to:

  _____ _____

  (Name of Person or Facility to receive information) (City, State, Phone #)
- I have reviewed Sleep Management Services Notice of Privacy Practices, which reviews how my medical information will be used and disclosed. I understand that I can receive a copy of this document.
- I consent and understand that staff physicians of Sleep Management Services may view my personal information as part of the procedures of Sleep Management Services.
- I understand that Sleep Management Services makes all attempts to verify my insurance and obtain any pre-certification or referral requested. However, in the case of a denial, I appoint Sleep Management Services to act as my authorized representative in requesting an appeal from my insurance regarding its denial of services / denial of payment. I also agree that if denial is overturned on appeal, payment should be made directly to Sleep Management Services as my authorized representative.
- I understand the dangers of drowsy driving, and attest that I will not engage in drowsy driving following the sleep study. I will inform my technician if I am too drowsy to drive and will make arrangements for someone to pick me up following testing if this occurs.
- **Authorization, Consent, Waiver and Disclosure Statement**

  I authorize my insurance carrier to pay directly to Sleep Partners LLC., Arkansas Neurology and / or Schluterman Neurology, the benefits due me for services rendered. I also agree that the above-named assignees may receive any such payments with my power of attorney and that receipt shall be acknowledgment by me that I have received benefits in the sum specified in such receipt. I acknowledge that my treatment plan may include referral to facilities in which my treating physician has financial interest. I understand that that there are certain services for which my health insurance may not cover and I am responsible for any deductibles, co-insurance, and/or non-covered services. I acknowledge that I will be charged a $25.00 fee for failing to keep a scheduled appointment without any notice. I understand that if I fail to pay my owed balance to Sleep Partners LLC., Arkansas Neurology or Schluterman Neurology, there will be a fee of 25-32% (of balance owed) added to my account to cover costs owed to the collection agency, depending upon whether legal action is required in collection attempts. I certify that all information on this form is true and accurate to the best of my knowledge.

  Medicare/Medicaid Certification

  I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment or authorized benefits be made on my behalf.

Signature of Patient:	Date:	Time: am/pm
Signature of Parent/Conservator/Guardian:	Relationship:	
Witness:	Date:	

Sleep Management Services

As required by the Privacy Regulations created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
This notice describes how health information about you (as a patient of our lab) may be used and disclosed, and how you can get access to you individually identifiable health information.

Please review this notice carefully

A. **Our commitment to your privacy:** Our lab is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act, (HIPAA). In conducting business, we will create records regarding you and the treatment and service we provide to you, we are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our laboratory concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated but, we must provide you with the following information and have in effect at the time.

- **How we may use and disclose your PHI**
- **Your privacy rights in your PHI**
- **Our obligation concerning the use and disclosure of your PHI**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revisions or amendment to this notice will be effective for all of your records that our lab has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times. You may request a copy of our most current Notice at any time.

- **If you have questions about this notice, please contact our office at 501-224-5200 located at 9305 Treasure Hill, Little Rock, AR 72227.**

B. **We may use and disclose your protected health information (PHI) in the following ways:**

1. **Treatment:** Our lab may disclose your PHI to other health care providers for purposes related to your treatment. For example your referring physician, interpreting physician and DME Company. Additionally, we may disclose your PHI to others who may assist in your care such as your spouse, children or parents.
2. **Payment:** Our lab may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations:** Our lab may use and disclose your PHI to operate our business. For example, we may disclose your PHI to other health care providers and entities to assist in the health care operations.
4. **Appointment Reminders:** Our lab may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options:** Our lab may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Health Related Benefits and Services:** Our lab may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of information to Family/Friends:** Our lab may use and disclose your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that another family member assist in obtaining treatment. In this case, that family member may have access to this medical information.
8. **Disclosures Required by Law:** Our lab may use and disclose your PHI when we are required to do so by federal, state or local law.

C. **Use and Disclosure of your PHI in Certain Special Circumstances:**

1. **Public Health Risks:** Our lab may use and disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse and neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
2. **Health Oversight Activities:** Our lab may use and disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include: investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights law and the health care system in general.
3. **Lawsuits and Similar Proceedings:** Our lab may use and disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceedings. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request of to obtain an order protecting the information the party has requested.
4. **Law Enforcement:** Our lab may use and disclose your PHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding a criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In and emergency, to report a crime (including the location or victim(s) for the crime, or the description, identity or location of the perpetrator.

SLEEP MANAGEMENT SERVICES
PATIENT PRE-STUDY QUESTIONNAIRE

Please print all information; let us know if you need any assistance completing the questionnaire.

Patient Name: _____ **Date:** _____

Address: _____ **City:** _____ **Zip:** _____

Date of Birth: _____**Social Security #:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Age: _____ **Male / Female** **Martial Status:** **Married** **Single** **Other**

Height: _____ **Weight:** _____ **Neck Size:** _____

Please provide the following information along with your insurance card.

Employer: _____ **Position:** _____

Primary Insurance: _____**Phone #**: _____

Name of Primary Insured Person: (if not patient) _____

SSN of primary insured:_____**DOB of primary insured:**_____

(We must have the above information to process your claim if you are not the primary card holder)

ID #:_____**Group #:**_____

PLEASE PROVIDE A COPY OF YOUR CARD TO THE TECHNICIAN; WE MUST HAVE A COPY TO CORRECTLY FILE YOUR INSURANCE. THANKS!

Secondary Insurance:_____**Phone #**:_____

ID #:_____**Group #**:_____

Emergency Contact:_____**Phone:**_____

Which doctor referred you to our sleep lab? _____

Who is your primary care physician? _____

(If different from referring physician)

Please mark your answers to the following questions. These questions will help us determine your diagnosis and help create a treatment plan for you.

SECTION 1

Which of these sleep disorders have you ever been diagnosed with or treated for?		
○ Obstructive Sleep Apnea	○ Restless Legs	○ Insomnia
○ Periodic Limb Movement Disorder	○ Central Sleep Apnea	○ Narcolepsy
○ None of these	○ Other:	○ Date diagnosed:
If you've had sleep apnea treatment, what sort of treatment did you have?		
○ CPAP	○ currently using CPAP	○ not using CPAP
○ Surgery	○ Dental Appliance	○ None of these
Which of these sleep problems are you experiencing?		
○ Excessive daytime sleepiness	○ Insomnia	○ Mood disorders
○ Habitual snoring	○ Impaired cognition	○ None of these

Have you been diagnosed with any of the following?		
○ Hypertension	○ Ischemic heart disease	
○ Stroke	○ None of these	
Are you claustrophobic?	Yes	No
Can you breathe freely out of both nostrils?	Yes	No

Positive airway pressure is the most reliable and cost effective way to treat obstructive sleep apnea. This treatment is provided by using a machine, a mask/headgear and hose system to deliver this pressure into your airway to keep it from collapsing during sleep. This equipment is provided by a DME (Durable Medical Equipment) Company. The following question relates to the DME Company.

Are you currently using a DME Company?	Yes	No
Name of company:		
If you have a preference for DME services please list:		
If this is a repeat titration study, please list any problems with your current treatment:		
END OF SECTION 1	**STOP HERE**	**CONTINUE TO SECTION 2**

Name/Initials:_____

SECTION 2

Please check, circle or fill in the following information

SLEEP PROBLEMS

○ Loud or Disruptive Snoring	○ Difficulty staying asleep	○ Memory Loss
○ Excessive fatigue/sleepiness	○ Difficulty falling asleep	○ Restless Legs
○ Choking/gasping during sleep	○ Oxygen drops at night	○ Sleep Walk or Talk
○ Witnessed Apnea (stopping breathing)	○ Morning headache	○ Grind teeth
○ Other:	○ Unusual behavior:	

HEALTH/ PAST MEDICAL HISTORY (Have you ever been diagnosed with the following?

○ Hypertension	○ Diabetes	○ Obesity	○ CHF	○ Ischemic Heart Disease
○ COPD	○ Seizures	○ Stroke	○ Atrial Fib	○ Migraine Headaches
○ Asthma	○ Allergies	○ Depression	○ Anxiety	○ Panic Disorder
○ Other:				

MEDICATIONS (Please list current medication and dose including OTC, supplements and vitamins.

Please list all medications you are allergic to:

GENERAL HABITS: (please check, circle or fill in the information to the following questions)

Do you function most poorly during the	○ morning ○ afternoon ○ evening?
On a typical day I drink: _____ cups caffeinated coffee _____ cups caffeinated tea _____ glasses caffeinated soda _____ glasses beer _____ glasses wine _____ glasses other alcohol	
Do you drink any of the above 2 hours or less before going to sleep?	Yes No
Do you smoke cigarettes?	Yes No Amt:
How many days per week do you exercise?	0 days 1-2 days 3-4 days 5-7 days

Name/Initials:_____

SLEEP HABITS

What are your usual working hours?	**WORK DAY**	**NON-WORK DAY**
What time do you go to bed?		
What time to you get out of bed?		
Do you nap during the day? What is the average length of each nap?	Yes _____ minutes	No
Are these naps intentional?	Yes	No
Did you nap today? Time of last nap: _____ AM / PM	Yes	No

PREPARING FOR SLEEP

On average, how long does it take you to fall asleep at night?	Less than 5 minutes 5 – 30 minutes 30 minutes – 1 hour	1 – 2 hours More than 2 hours
How often do you use medication or alcohol to help you fall asleep? **Medication Name:**_____	Never 3 – 5 times/week Every night	1 – 2 times/week 1 – 2 times/month
Do you have a strong urge to move your legs while sitting or lying down?	Yes	No
Do these symptoms get worse with sitting or lying down especially during the late evening and at night?	Yes	No
Do you get relief with activity such as walking, stretching or bending at least temporarily?	Yes	No

DURING SLEEP

Do you wake up frequently during the night?	Yes No	_____number of times
What do you do when you are awake?		
How long do you stay awake?	_____ minutes	
Do you awaken from sleep with heartburn?	Yes No	
Do you sweat excessively during sleep?	Yes No	
Does pain disturb your sleep? **Describe:**	Yes No	

Name/Initials:_____

AWAKE

How do you feel when you wake up in the morning?	Always	Often	Rarely	Never
Tired (want to continue sleeping)				
Suffer from pains or stiffness				
Unpleasantly dry mouth				
How often does your sleep problem interfere with your daily functioning?				

As a result of sleepiness, have you experienced any of the following?

Auto accident Poor work performance or work related injury Reduction in quality of life

Have you fallen asleep during day or evening activities or in a dangerous situation?	Yes	No

Describe:

Have you ever been paralyzed (unable to move all of your muscles) for a short time when you first awaken?	Yes	No
When you are laughing, surprised or angry, do your muscles become weak (jaw drooping, leg buckling, or falling down)?	Yes	No

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, Use the following scale to choose the most appropriate number for each situation:

0 = No chance 1 = Slight chance 2 = Moderate chance 3 = High chance

SITUATION ***Please circle the appropriate number that relates to the scale given above***	**CHANCE OF DOZING**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (i.e.: meeting, theater)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking with someone	0 1 2 3
Sitting quietly after lunch, without alcohol	0 1 2 3
Driving a car, or while stopped in traffic	0 1 2 3

Thank you for allowing us to care for you, if you need anything during the night please do not hesitate to let your technician know.

Name/Initials:_____