

Sleep Study Consent Form

I authorize a Nocturnal Polysomnogram, CPAP titration study, MSLT or MWT to be performed under the medical direction of Singar Jagedeesan M.D., Medical Director of Wake *Sleep* Sleep Disorders Center.

The nature and purpose of this procedure, as well as the risks involved, and possible complications have been explained to me. No individual with Wake *Sleep* Sleep Disorders Center, or any other physician's office has given me a guarantee or assurance as to the results that may be attained from this study.

I understand that my study may be video and/or audio recorded for documentation of certain problems, such as restless leg movements, "night terrors", combative sleep, or at the request of my referring physician and for the safety of the patient or technician in a given situation. This recording will be used for diagnostic purposes only and will be kept long enough for the medical director or referring physician to confirm a diagnosis.

If necessary, I authorize administration of such medication (s) as deemed by the physician for the study. I hereby give permission to release any medical information on myself that may be deemed necessary as a part of this procedure. I also understand and consent to the results of this procedure being released to other physicians or medical equipment companies, deemed necessary for my continued care.

I consent to the release of medical records in the process of billing any insurance claims. I understand that Wake *Sleep* Sleep Disorders Center will manage the billing of this procedure and assign any benefits paid on my behalf to the Wake *Sleep* Sleep Disorders Center.

(Signature of Patient or Guardian of Patient)

Date

(Witness Signature)

Date

HIPAA Notice of Privacy Practices

Wake Sleep, Sleep Disorders Center

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **October 01, 2006.**

WakeSleep

Sleep Disorders Center

FINANCIAL POLICY

Effective January 1, 2008

At Wake Sleep we are committed to providing you with the best possible care and take pride in our work. To assist us in our record keeping it is imperative that all patients complete the patient information form at the time of the initial visit before seeing the physician.

INSURANCE: If you have health insurance we will help you receive maximum benefits. Please provide us with your insurance card for verification. Our office staff will be glad to file insurance for you provided you supply the proper forms and information. Please note that professional services are charged to you and not to the insurance company. You are fully responsible for timely payment of your account. We accept assignment from several HMO's, PPO's, and Managed Care insurances: BCBS, Aetna, United Healthcare, Cigna, etc. Ask if you have any questions about your particular insurance.

DEDUCTIBLES AND CO-PAYMENTS: are to be paid at the time service is rendered.

STATEMENTS: Statements will be sent out on a monthly basis and are due upon receipt. If your balance has reached 90 days, and you have made no attempt in paying your bill then a \$25.00 collection fee will be charged to your account and the account will be sent to collections.

PERSONAL INJURY/LIABILITY CASES: Our office does not accept liens. You and not your attorney is responsible for the visit at the time of service. However, we do accept some Workman's Compensation cases. If you are not sure yours is one, please ask the office staff.

MISSED APPOINTMENTS: Our office staff will charge a fee of \$200.00 for MISSED SLEEP STUDY APPOINTMENTS A 24 hour notice is required to waive these fees.

NO INSURANCE: If you have no insurance coverage, you are expected to pay in full before each visit.

BAD CHECKS NSF CHECKS: There will be a fee of \$35.00 for any NSF checks and this amount will be due in our office immediately to avoid additional fees. We will not redeposit checks.

We accept cash, checks, money orders American Express and Visa/ Mastercard only.
I HAVE READ THE ABOVE FINANCIAL POLICY AND UNDERSTAND MY RESPONSIBILITIES

Signature: _____

Date: _____

Parent or Guardian: _____

Date: _____

Patient Sleep Questionnaire

Name: _____ Date: _____

Height: _____ Weight: _____ DOB: _____

Reason for sleep evaluation _____

Referring Physician _____

How long have you had this problem? _____

Mark any of the occurrences that either you or someone else has observed of you:

<input type="checkbox"/> Snoring	<input type="checkbox"/> Acting Out Dreams	<input type="checkbox"/> Creeping/Crawling Feeling In Legs
<input type="checkbox"/> Leg Jerks	<input type="checkbox"/> Nighttime Wheezing	<input type="checkbox"/> Feel The Need To Move Your Legs
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Sleep Walking	<input type="checkbox"/> Vivid Dreams/Nightmares
<input type="checkbox"/> Talking In Sleep	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Pain That Interferes With Sleep
<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Wake Up Gasping For Air	<input type="checkbox"/> Awaken With Dry Mouth
<input type="checkbox"/> Sleep Disrupting Ideas	<input type="checkbox"/> Sleep Disrupting Ideas	<input type="checkbox"/> Stop Breathing While Sleeping

Estimate your risk of falling asleep in the following situations, using this scale:

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

Sitting and reading :	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lying down to rest in the afternoon :	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching TV :	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
As a passenger in a car, for an hour, with no break :	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting, inactive, in public (Theater, Meetings, Etc.) :	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after lunch, without Alcohol:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
In a car, stopped in traffic, for a few minutes:	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Total _____

Please list all your medications that you are currently taken:

Past or Current Medical Problems: _____

Do you have a history of: (Please check all boxes that apply)

<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Seizures/Other Neurological Diseases	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug or Alcohol Addiction	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Deviated Nasal Septum	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Thyroid Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression

Is there anyone in your family with the following conditions?

<input type="checkbox"/> Seizures	<input type="checkbox"/> Dementia	<input type="checkbox"/> Excessive Sleepiness	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> None

If you marked any of the above conditions please list relationship to effected person:

Is your Nighttime sleep refreshing? Yes No

Are you sleepy/fatigued during the day? Yes No

If you snore, what sleeping positions do you snore in? Back Side Stomach

Does your snoring disturb others? Yes No

What positions do you sleep in: Back Side Stomach

Mark any of the following that you do while you are in bed:

Read Eat Watch TV Do work activities Sleep with the TV on

How many times do you wake to use the restroom? _____

How long does it take you to fall back to sleep? _____

If you have difficulty falling asleep, what do you do? _____

Do you take naps? Yes No

If yes, how long are they? _____

Do you dream during the naps? Yes No

Are the naps refreshing? Yes No

Do you exercise? Yes No

If yes, what time of day do you exercise? _____

Have you had your tonsils removed? Yes No If so, at what age? _____

Do you work shift work? _____

If so, what shifts? _____

Do you smoke? Yes No

If so, for how many years and how much? _____

Do you drink Alcohol? Yes No

If so, how many drinks per week? _____

Do you drink coffee, caffeinated soda, or tea? Yes No

If so, how many cups per day? _____