

Patient Sleep Questionnaire

Name: _____ Date: _____

Height: _____ Weight: _____ DOB: _____

Reason for sleep evaluation: _____

Physician that referred you: _____

How long have you had this problem? _____

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

Snoring	Acting Out Dreams	Creeping/Crawling Feeling In Legs
Leg Jerks	Nighttime Wheezing	Feel The Need To Move Your Legs
Restless Sleep	Sleep Walking	Vivid Dreams/Nightmares
Talking In Sleep	Morning Headaches	Pain That Interferes With Sleep
Teeth Grinding	Wake Up Gasping For Air	Awaken With Dry Mouth
Sleep Disrupting Ideas	Sleep Disrupting Ideas	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 :	0	1	2	3
Lying down to rest in the afternoon :	0	1	2	3
Watching TV :	0	1	2	3
As a passenger in a car, for an hour, with no break :	0	1	2	3
Sitting, inactive, in public (Theater, Meetings, Etc.) :	0	1	2	3
Sitting quietly after lunch, without Alcohol:	0	1	2	3
Sitting and talking to someone:	0	1	2	3
In a car, stopped in traffic, for a few minutes:	0	1	2	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

Stroke or TIA	Seizures/Other Neurological Diseases	High Blood Pressure
Diabetes	Drug or Alcohol Addiction	Kidney Disease

Heart Disease	Deviated Nasal Septum	Lung Disease
Thyroid Issues	Anxiety	Depression

Is there anyone in your family with the following conditions?

Seizures	Dementia	Excessive Sleepiness	Parkinson's Disease
Narcolepsy	Insomnia	Sleep Apnea	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?_____

Wake Sleep and Wake Neurology HIPPA Notice of Privacy Practices

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.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physicians, our office staff and others outside of your office that are involved in your care and treatment for 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 coordinator or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides to you. For example, your protected health information may be provided to physicians 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 for your physicians 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 student 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 physicians are 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 Disease: 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 physicians or the physician's practice has taken an action in reliance on the use or disclosure indication 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.

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 physicians are not required to agree to a restriction that you may request. If a 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 to 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 have the right to have your physician amend your protected health information. If we deny your requests 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 complain wit us by notifying our privacy contact of you complaint. **We will not retaliate against you for filing a complaint.**



1230 SE Maynard Road
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I have received Wake Sleep & Neurology's Notice of Privacy Practices. I understand that Wake Sleep and Neurology may use and disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Wake Sleep & Neurology Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

(Patient Name) (Patient Signature) (Date)

If the patient is a minor, please have parent or legal guardian sign and date below.

(Patient Name) (Patient Signature) (Date)

I authorize Wake Sleep & Neurology's staff to leave messages regarding my personal health information and/or appointment reminders at:

My home telephone number My work telephone number My cell phone number
Yes No Yes No Yes No

I authorize Wake Sleep and Neurology's staff to discuss my personal health information with the following people:

WAKE SLEEP & NEUROLOGY

Phone 919-463-1101 Fax 919-463-1110

Patient Information Sheet

Date ____ / ____ / ____

NAME: LAST _____ FIRST _____ MIDDLE INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ CELL PHONE (_____) _____ - _____

WORK PHONE (_____) _____ - _____ EXT. _____

EMAIL ADDRESS: _____ @ _____

PRIMARY CARE DOCTOR _____

REFERRING PHYSICIAN _____

DATE OF BIRTH ____ / ____ / ____ SEX F M SOCIAL SECURITY # ____ / ____ / ____

MARITAL STATUS: SINGLE DIVORCED LEGALLY SEPARATED PARTNER
 MARRIED (SPOUSE NAME _____) WIDOWED UNKNOWN

EMPLOYER NAME _____ ADDRESS _____

EMPLOYMENT: FULL TIME NOT EMPLOYED RETIRED PART TIME SELF EMPLOYED ACTIVE MILITARY

STUDENT STATUS: FULL TIME PART TIME NOT A STUDENT
RESPONSIBLE PARTY: SELF GUARANTOR RELATIONSHIP _____

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ DOB ____ / ____ / ____

EMERGENCY CONTACT:

NAME LAST _____ FIRST _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (_____) _____ - _____ EXT. _____

PERMISSION TO LEAVE MESSAGE: HOME YES NO WORK YES NO

AUTHORIZATION TO RELEASE INFORMATION TO: NAME _____ RELATIONSHIP _____
PHONE (_____) _____ - _____

PRIMARY INSURANCE _____ POLICY HOLDER NAME _____

POLICY HOLDER SEX F M POLICY HOLDER DOB ____ / ____ / ____

POLICY HOLDER SSN # _____ - _____ - _____ POLICY HOLDER RELATIONSHIP TO PATIENT _____

ID# _____ GROUP # _____

SECONDARY INSURANCE _____ POLICY HOLDER NAME _____

POLICY HOLDER SEX F M POLICY HOLDER DOB ____ / ____ / ____

POLICY HOLDER SSN # _____ - _____ - _____ POLICY HOLDER RELATIONSHIP TO PATIENT _____

ID# _____ GROUP # _____

PATIENT, PLEASE SIGN FOR PERMISSION TO TREAT IF PATIENT IS A MINOR, PARENTS SIGN TO TREAT IN YOUR ABSENCE _____ Date _____

FINANCIAL POLICY

Effective January 1, 2008

At Wake Sleep & Neurology we are committed to provide 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.

MEDICAID: We accept NC Medicaid only!! Co-Pay of \$3.00 must be paid at the time service is rendered.

FORMS: There will be a \$15.00 fee for completing disability and special insurance forms and a \$20.00 fee for DMV forms. All forms must be paid for upon receipt.

MISSED APPOINTMENTS: Our office staff will charge a fee of \$35.00 for MISSED APPOINTMENTS for Neurology, a \$200.00 fee for SLEEP STUDIES and a fee of \$50.00 for MISSED DIAGNOSTIC STUDIES. 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: _____

IMPORTANT INFORMATION REGARDING YOUR SLEEP STUDY

Thank you for choosing Wake Sleep Center. The following are some guidelines to help you prepare for your sleep study.

Your appointment has been scheduled for 8 pm. It will take about 1 hour for the sleep technician to apply all your sensors. You will be able to relax, read or watch TV before your bedtime.

- Please do not arrive at the sleep center more than 15 minutes before your scheduled time.
- Enclosed you will find a sleep questionnaire and other forms that you will need to fill out and bring with you the night of your sleep study.
- **Please bring your pajamas or appropriate attire, robe, slippers and any toiletries you may need during the study. We will provide pillows, although you are welcome to bring your own pillow if you would like.**
- Please shower and wash your hair prior to coming in for your sleep study, this will help remove skin oils. Please do not apply any hair spray or creams.
- If you are taking any prescribed medications, please continue to take them, unless you are advised otherwise.
- Please do not bring any valuables with you to your sleep study.
- Wake Sleep Center now has 2 sites to serve you better. Please be sure to check to see if you are scheduled at the Raleigh or Cary location.
- You will be released in the morning between 6:00 and 7:00. In unusual cases your physician may wish you to remain the following day for additional testing. If additional testing is needed you would be released around 4:00pm.

If it becomes necessary to cancel or reschedule your appointment, please notify us as soon as possible so we may reassign your appointment to another patient.

If you cancel a scheduled study without giving 48 hrs notice you may be charged a \$200.00 cancellation fee so that we may cover expenses.

If you have any questions call our office at (919) 463-1101.