Georgetown Sleep Center

Experienced care to put your sleep problem to rest.

REGISTRATION FORM

Patient's Name:_____ Social Security #:_____

Last *First* *M*

Date of Birth: ____/____/_____ Age: ____ Sex: _____ Marital Status: _____

Home Address: _____

Street, City, State and Zip

Primary Phone: _____ Alternate Phone: _____

Employer: _____ Work Phone: _____

Email: _____

IN CASE OF EMERGENCY, NOTIFY: _____Relationship:_____Phone: _____

RESPONSIBLE PARTY INFORMATION -IF OTHER THAN THE PATIENT:

Guarantor's Name: _____ Date of Birth: ___/___/_____ SS#: _____

Home Address: _____

Street, City, State and Zip

Primary Phone: _____ Work Phone: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated and assign directly to Georgetown Sleep Center all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____

PATIENT/GUARDIAN (If patient is a minor) SIGNATURE RELATIONSHIP DATE

Georgetown Sleep Center

Patient Name:_____ Date of Birth:_____

Race (Please check one):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other Race
- ☐ Refuse to Report/Decline to Specify

Ethnicity (Please check one):

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Refuse to Report/Decline to Specify

RELEASE OF INFORMATION

I authorize Georgetown Sleep Center to release information which may include diagnosis, records of any treatment, or any examinations rendered to:

Please print name(s)

☐ Spouse:_____ ☐ Parent: _____

☐ Other: _____

_____ _____

Patient Signature Date

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ SEX:_____ DATE: _____

DOB: _____ AGE: _____ Primary Doctor / Care Provider: _____

Pharmacy Name/Address: _____

Pharmacy Phone #: _____

Chief sleep related complaint: _____

What made you decide to have this problem evaluated? _____

How do problems with sleep affect your quality of life? _____

Have you ever had a sleep study before? _____ When? _____Where? _____

USE THIS SCALE AND CIRCLE 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

Sitting and reading	⊙0 ○1 ○2 ○3
Watching TV	⊙0 ○1 ○2 ○3
Sitting in a public place for example, a theatre or meeting	⊙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	⊙0 ○1 ○2 ○3
Sitting and talking to someone	⊙0 ○1 ○2 ○3
Sitting quietly after lunch (when you have had no alcohol)	⊙0 ○1 ○2 ○3
In a car, while stopped in traffic	⊙0 ○1 ○2 ○3

SELECT ALL THAT APPLY

- ☐ **Snoring** [Mild - Moderate – Loud - On my back - All positions]
- ☐ **I wake up** [Choking - Coughing - Gasping - Smothering - Snoring - Sweating]
- ☐ **Told I stop breathing in my sleep** [Spouse – Partner – Family – Friends]
- ☐ **I disturb my bed partner** [Sometimes - Most nights]
- ☐ **We sleep in different rooms** [Sometimes - Most nights]
- ☐ **Get up to go to the bathroom** [0 - 1 – 2 – 3 – Multiple] times each night
- ☐ **Heart** [RACING – POUNDING – PALPITATIONS] at night
- ☐ **Restless sleep**
- ☐ **Morning dry mouth or sore throat**
- ☐ **Morning headaches** [Daily – Occasional]
- ☐ **I wake up feeling** [Refreshed – Tired – Worse than the night before]
- ☐ **I sleep through my alarm.**
- ☐ **I have trouble getting to work on time.**
- ☐ **During the day, I feel** [Tired, Fatigued, Sleepy, Exhausted)
- ☐ **I have trouble staying awake** [Driving – Work – Meetings – Reading – Watching TV]
- ☐ **I struggle with** [Memory – Attention – Concentration – Judgment – Motivation]
- ☐ **My mood is** [Depressed – Irritable – Anxious – Angry]
- ☐ **I can drive for miles and not realize how I got somewhere**
- ☐ **I drink** [Coffee – Tea –Sodas – Energy Drinks] [_____ cups/drinks per day]
- ☐ **I nap** [Daily – Weekends] [_____ times per week].

How long have you had these symptoms? _____

SLEEP HABITS

What time do you get into bed? Weekdays _____ Weekends _____
What time do you get out of the bed? Weekdays _____ Weekends _____

What is your typical sleeping position? [Back - Side – Stomach – Recliner]
What is the setting of your thermostat? _____ degrees
How many hours do you sleep on the average night? _____
How many hours do you spend napping on the average day? _____
With whom do you share the bedroom? [Spouse - Partner – Children – Pets]
Which best describes you? [Night owl – Morning person]

Pre-sleep routine (Select all that apply)

- [x] **I watch TV** [In the bedroom - In another room – Both]
- [ ] **The TV is on all night**
- [ ] **I read** [In the bedroom – In another room – Both]
- [ ] **I spend time on the computer**
- [ ] **I play video games**
- [ ] **I spend time on work or studying**
- [ ] **I exercise within 3 hours of bed**
- [ ] **I drink alcohol** [☐Beer ☐Wine ☐Liquor ☐Every Night - ____ Nights per week]
- [ ] **I shower or bathe**

INSOMNIA (SELECT ALL THAT APPLY) --- CHECK N/A IF NONE APPLY: ☐ N/A

- [ ] **I have trouble falling asleep** [_____ Nights per week – Every night]
- [ ] **I have trouble staying asleep**
- [ ] **I wake up early in the morning and can't go back to sleep**
- [ ] **I can tell when I am not going to be able to fall asleep**
- [ ] **I worry about being unable to fall asleep**
- [ ] **I worry about the consequences of lack of sleep**
- [ ] **Thoughts are racing through my mind when I try to go to sleep**
- [ ] **I have increased muscle tension at night**
- [ ] **I am unable to fall asleep without taking medication**
- [ ] **I have more trouble sleeping** [At home – Hotels – Vacation – Travel]
- [ ] **I have trouble sleeping at night if I nap during the day**
- [ ] **I get up to eat at night**
- [ ] **I watch the alarm clock at night**

When did this problem start? _____
How long does it take you to fall asleep? _____
What do you do if you cannot fall asleep? _____
How many times do you wake up each night? _____
If you wake up, how long does it take you to return to sleep? _____
Is there anything about your bed partner or sleeping environment that interferes with your sleep?
_____
How many days per week do you take medication for sleep? _____
What is your current sleep medication? _____
What time do you take the medication? _____
How long does it take the medication to work? _____
Have you ever had a bad reaction to a sleep medication? _____
Have you ever seen a psychologist for treatment of insomnia? _____

MOVEMENT DISORDERS (SELECT ALL THAT APPLY)- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **Before sleep, I have an urge to move my legs or arms**
- ☐ **My legs or arms feel uncomfortable** ☐Tight ☐Restless ☐Tingle ☐Crawling sensation]
- ☐ **Movement of the limbs causes a sense of relief**
- ☐ **These symptoms start or get worse at night or in the evening**
- ☐ **At times, I am unable to hold still when sitting in a chair or lying in bed.**
- ☐ **My legs or arms continue to move or jerk during sleep.**
- ☐ **I have a history of iron deficiency or anemia**
- ☐ **I donate blood** [How often? _____]

What time does the restlessness or discomfort in the legs start? _____
How long have you had this movement problem? _____
How many nights per week? _____
Are symptoms made worse by [Caffeine – Alcohol – Medications – Exercise]
Have you taken medication to treat these symptoms? _____

- ☐ **Just as I am falling asleep, my muscles jerk**
- ☐ **I grind or clench my teeth during sleep**
- ☐ **I wear a mouth guard** (bite splint)

BEHAVIOR IN SLEEP (SELECT ALL THAT APPLY)--- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **Sleepwalking** ☐Childhood ☐Currently ☐Ambien]
- ☐ **I get up to eat during sleep, and I don't remember doing it.**
- ☐ **I talk in my sleep**
- ☐ **I suddenly rouse from sleep with panic and confusion**
- ☐ **I have bad dreams or nightmares** [_____ Nights per week – Nightly]
- ☐ **I physically act out what I am dreaming about**
- ☐ **I have hurt myself or my bed partner during sleep**
- ☐ **I do not remember my dreams**
- ☐ **I have other abnormal behavior at night** _____

How long have you had this abnormal behavior? _____
Have you ever been treated for this condition? _____

NARCOLEPSY AND DISORDERS OF SEVERE SLEEPINESS -- CHECK N/A IF NONE APPLY: ☐ **N/A**

- ☐ **I have sleep attacks where I fall asleep without warning or against my will**
- ☐ **Short naps (less than 30 minutes) are refreshing.**
- ☐ **When struck by a sudden emotion** [Laughter – Excitement – Anxiety], **my muscles become weak.** [Drop things – Collapse – Weak in the knees – Face feels weak – Hands feel weak – I have trouble talking – I lean against the wall – I sit down]
- ☐ **I feel paralyzed or unable to move when falling asleep or when waking up.**
- ☐ **I visually hallucinate or see things in the room when I am falling asleep or when I wake from sleep.**
- ☐ **I routinely dream during naps.**
- ☐ **No matter how long I sleep, I never feel rested or fully awake.**

How old were you when these symptoms started? _____
Have you ever had an accident as a result of falling asleep while driving? _____
Have you ever taken medication to treat these symptoms? _____

CIRCLE ALL MEDICATIONS THAT YOU HAVE PREVIOUSLY TRIED FOR SLEEP:

Ambien/zolpidem ☐	AmbienCR/zolpidemER ☐	Intermezzo ☐	Lunesta ☐	Edluar ☐
Sonata/zaleplon ☐	Seroquel/quetiapine ☐	Silenor ☐	Rozerem ☐	Belsomra ☐
Restoril/temazepam ☐	Desyrel/trazodone ☐	Melatonin ☐	Valerian ☐	Other ☐
Remeron/mirtazepine ☐	Elavil/amitriptyline ☐	Tylenol Pm ☐	Benadryl ☐	

PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS OR PROVIDE A COPY OF YOUR LIST.

NAME of Medication	DOSE	FREQUENCY

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)-- CHECK N/A IF NONE APPLY: ☐ N/A

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Arrhythmia
- ☐ Diabetes
- ☐ High cholesterol
- ☐ Stroke
- ☐ TIA
- ☐ Asthma (Childhood) (Current)
- ☐ COPD / Emphysema
- ☐ Nasal Allergies (seasonal) (all year)
- ☐ Sinus Infections ___ times/year
- ☐ Strep Throat ___ times/year
- ☐ Acid Reflux / Heartburn
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Colon Disease / Hemorrhoids
- ☐ Anemia
- ☐ Cancer (Type:_____)
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ Post Traumatic Stress Disorder
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Thyroid Disease
- ☐ Menopause
- ☐ Pregnancy
- ☐ Migraine
- ☐ Neuropathy
- ☐ Epilepsy / Seizures
- ☐ Head Injury / TBI
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Arthritis
- ☐ (Alcohol) (Drug) (Medication) Addiction
- ☐ ADD/ ADHD

Additional :

- ☐ _____
- ☐ _____

Georgetown Sleep Center, PA Patient Consent - Notice of Privacy Practices/ Assignment of Benefits/Financial Policy/Release of Information:

I authorize all staff at Georgetown Sleep Center, PA to provide treatment as necessary. I acknowledge that no guarantees can be made to me as to the outcome of treatment. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I authorize my insurance benefits to be paid directly to my physician realizing I am responsible to pay non-covered and/or denied services. In the event that my insurance carrier denies payment for any reason, I acknowledge that I am responsible for payment of services provided to me.

Financial Policy-Georgetown Sleep Center, PA

We require payment at time of service and will accept personal checks, cash, VISA, MasterCard, American Express, and Discover. Our practice accepts most major insurance carriers and we will file your claim with your insurance company. We strongly believe that the best medical service is based on a mutual relationship of trust, confidence and respect. We therefore invite you to discuss with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our Business/Billing Office at (512) 212-3202.

Payment Options:
Private Pay/ Uninsured Patients: We strive to provide quality care for those in our community that do not have access to affordable health care coverage. Payment is expected at the time services are rendered. Therefore, our Self Pay Patients may receive a special discounted fee at the time of check out. For extensive services you may secure a loan with your financial institution or Credit Card Company.

Insured Patients: You must provide a current copy of your insurance card to the receptionist at the time of service. You must pay all deductibles, copayments, and co-insurances in full at the time of service or promptly when you receive a statement. You may choose to pay with cash, check, or credit card. Georgetown Sleep Center will file your insurance claim with your carrier. Although we may estimate the portion your insurance may pay, it is the insurance company that makes the final determination of eligibility and payment. Insurance is a contract between you and your insurance company. Per your insurance contract, it is your obligation to pay those charges not covered by your insurance company.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. Payments not received within 25 business days of receipt of this statement are considered past due. If you have a credit on your account, it is the patient's responsibility to request the refund on their account. Any refund balance left in the account after six months could forfeit a $30 administrative fee for processing. Please request refunds after receiving a final statement from your insurance Plan.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. These accounts will receive a past due letter and are subject to collection activity. This includes account review for collection agency follow-up and reporting. If your account is sent to an outside collection agency, you may be subject to agency fees, penalties and credit bureau reporting.

Missed Appointments: We understand that our patients' time is valuable and we know that our patients understand that the physician's time is valuable as well. Therefore, a missed appointment fee will be assessed to any appointment not cancelled without prior notice. For office visits, a 24 hour cancellation is required to avoid the $35.00 missed appointment fee. For sleep studies, we require a 72 hour cancellation notice or $250.00 will be charged to your account. Full payment of these fees will be required before rescheduling your appointment. ***Please remember that appointment confirmation is provided as a courtesy only and it is the patient's responsibility to remember their appointment time.**

Good medical care requires a mutual relationship of trust, confidence and respect. Persistent failure to keep scheduled appointments may result in dismissal from the practice.

Returned Checks: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to making a new appointment. Future visits will need to be paid in cash. All returned checks left unpaid after 25 days will be considered past due.

Workers Compensation/Personal Injury:
We do not accept Worker's Compensation or Personal Injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time services are rendered.

____ **Medicaid**
We do not accept or file Medicaid claims primary or secondary.

Additional Services: Please be aware that there may be fees for additional services such as medical records, depositions, or special forms. Please check with the Office Manager for specific fees for additional services.

Any disputes of your account should be done in writing within 25 days of the receipt of your statement. Your dispute will be addressed immediately and you will be notified of the outcome within 30 days of the receipt of your dispute.

RELEASE OF INFORMATION

I hereby authorize Georgetown Sleep Center to release my information to my medical provider such as physician, medical equipment company, emergency medical services (transport), or hospital as well as any insurance company and/or responsible billing party in order to carry out medical treatment, payment and healthcare operations. This information may include diagnosis, records of any treatment, or any examinations rendered.

I authorize the release of information to my insurance carrier concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and any physician I am recommended to see for continuation of care. Any release of information to individuals of my choosing will be authorized in the office. I understand that the release of information will only consist of medical records belonging to Georgetown Sleep Center, PA.

I understand all online communications will be used only for limited purposes. If there is any information that I do not want transmitted via online communication, I must inform this practice in writing. I understand this office cannot be held responsible.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician staff and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

Print Patient Name_____ Patient Date of Birth_____

_____ _____

Patient's Signature Date

This is an agreement between Georgetown Sleep Center, PA and the Patient named on this form. By executing this agreement, you (the Patient/Guarantor) are agreeing to pay for all services rendered. Please understand that insurance coverage is not a guarantee of benefits and does not release you from any financial obligation to pay for services rendered by Georgetown Sleep Center, P.A.

Georgetown Sleep Center, PA

Patient Email Consent Form

Many patients prefer the convenience of electronic mail ("e-mail") to other forms of communication. Georgetown Sleep Center offers patients the opportunity to communicate by e-mail. Georgetown Sleep Center will follow the practice's Electronic Mail Policy. As provided in that policy, patients will be required to meet face-to-face with the physician at his/her discretion.

Patient Treatment and Diagnosis: No emails containing Patient Treatment and Diagnosis will be emailed to the patient. All outside communication regarding Patient Treatment and Diagnosis will be physically mailed, or added to the secure link provided through the Electronic Health Record. **Disclosures within Georgetown Sleep Center Office:** Georgetown Sleep Center may forward or send e-mails internally to workforce members as necessary for diagnosis and treatment or to 3rd parties such as billing. **Patient Scheduling:** Georgetown Sleep Center may email scheduling information to the patient if asked.

Although Georgetown Sleep Center acknowledges the conveniences of e-mail, transmitting patient information by e-mail has a number of risks that you should seriously consider prior to using e-mail. These risks include, but are not limited to, the following:

- E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily send an e-mail to the wrong address.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

Taking into account these risks, Georgetown Sleep Center will use reasonable means to protect the security and confidentiality of e-mail communications as required by HIPAA, HITECH and Texas Law. However, it is impossible for Georgetown Sleep Center to guarantee the security and confidentiality of e-mail communications. Should confidential information be improperly disclosed, through no fault of Georgetown Sleep Center, Georgetown Sleep Center will not be liable for such disclosures.

E-MAIL SHOULD NOT BE USED FOR MEDICAL EMERGENCIES: Georgetown Sleep Center will make every effort to read and respond to an e-mail from you. Georgetown Sleep Center cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Therefore, should you need immediate assistance, please call Georgetown Sleep Center or your physician's office. By consenting to communicate with Georgetown Sleep Center through e-mail, you also agree to the following responsibilities:

- If you send an e-mail to Georgetown Sleep Center that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify Georgetown Sleep Center that the e-mail was received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule appointments.
- You should NOT use e-mail in order to make disclosures about sensitive medical information such as:
  a. Substance Abuse
  b. AIDS/HIV
- It is your responsibility to inform Georgetown Sleep Center of any changes to your e-mail address.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail as set forth in this consent form. Despite the risks associated with e-mail, I agree that Georgetown Sleep Center and his/her workforce may use e-mail to facilitate communications to me.

Patient Signature: _____ Date: _____ Email Address: _____

Should you want to restrict any other kind of information that may be disclosed through the use of e-mail, please list the restrictions:

_____

_____

_____

Georgetown Sleep Center is not required to comply with your request. If we choose not to comply, we will not communicate with you via e-mail. Should you wish to revoke this consent, revocation must be made in written form or e-mail. In either case, the revocation must be addressed to ___*Ryan Charriere – HIPAA Officer*, who may be contacted at the following address or e-mail: ___ryan.charriere@georgetownsleepcenter.com___

Witness Signature: _____ Date: _____

Georgetown Sleep Center <u>does not</u> have permission to use email to communicate with me.

Patient Signature: _____ Date: _____