SleepRite CENTER

PATIENT INFORMATION

Date: _____

1. DEMOGRAPHICS

Patient Name: _____ SSN: _____

Date of Birth: _____ Age: _____ Gender: ☐ Female ☐ Male

Home #: _____ Work #: _____ Cell #: _____

Mailing Address:_____

City: _____ State: _____ Zip Code _____

Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone #: _____ Alternate #: _____

2. INSURANCE

- Primary

Insurance Carrier: _____ ID #: _____

Primary Insured: _____ Relationship to Insured: _____

Insured D.O.B: _____ Insured SSN: _____

- Secondary

Insurance Carrier: _____ ID #: _____

Primary Insured: _____ Relationship to Insured: _____

Insured D.O.B: _____ Insured SSN: _____

SLEEP RITE
CONSENT FOR POLYSOMNOGRAPHY

Details
A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

- Brain waves
- Heart rate
- Breathing rate
- Oxygen level
- Eye movements
- Chin movement

The study also may involve other sensors. The sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you.

Risks
There is no major health risk involved with this sleep study.

Agreement
My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technician will attach sensors to my body for the study.
3. The removal of the sensors in the morning may irritate my skin and cause redness.
4. A video camera will record me as I sleep. A technician will watch me on a monitor in the control room.
5. I will be free to roll over and move in bed during the study.
6. I will need to ask for help if I must get out of bed for any reason.
7. The technician may need to enter the room to wake me if there is a problem.
8. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
9. I understand why I am taking this sleep study.
10. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.

_____ _____
Signature (Patient or Guardian) **Date**

_____ _____
Signature (Witness) **Date**

SLEEP RITE
PERMISSION TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO

I, _____,
Patient/Guardian

hereby authorize Sleep Rite Center, or their representative, to take photograph(s) and/or record audio and video

of _____.
Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. SleepRite and trustees and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to the Sleep Rite Center the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

Check here if you do NOT authorize use for educational purposes.

_____

Signature (patient or guardian) Date

Relationship to Patient if Guardian _____

_____

Witness Date

AUTHORIZATION TO RELEASE INFORMATION

SLEEP RITE
3434 Saratoga, Suite 101
Corpus Christi, Texas 78415
361-288-1855

Patient Name _____ **Patient DOB**_____

I, _____,
Patient/Guardian

hereby authorize Sleep Rite Center to release requested medical information from the medical chart of

_____
Name of Patient

to my referring physician and/or my insurance company.

I have indicated (circled) below any restrictions on the medical information that may be released.

Name of patient

Date of birth

Name at time of treatment

Social security number

Telephone number

Address

_____ _____
Patient/Guardian Signature Date

This information has been disclosed from records whose confidentiality may be protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit medical providers from making further disclosure of this information except with the expressed, written consent of the person to whom it pertains. A general authorization for release of information, if held by another party, is insufficient for this purpose.

SLEEP RITE
PATIENT BILL OF RIGHTS

SleepRite Center has created a Patient Bill of Rights to help provide you with the best possible care. Your rights as a patient are outlined below.

You have the right to:

- Respectful care. You are to be treated respectfully.
- Be informed of about your diagnosis, to know what your treatment options are, and understand what the potential outcomes of each treatment should be.
- Know the names of those treating you.
- Refuse treatment, as permitted by law. You can refuse treatment and still receive alternate care.
- Privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give expressed consent.
- Access to your medical records at any time. You can also have the information explained to you.
- Know about any facility rules regarding patient care

You are responsible for:

- Being considerate of the needs of other patients in the facility.
- Providing health care insurance information when asked for it.

We will provide you with information regarding your benefits for this procedure as relayed to us by your insurance company.

I hereby acknowledge the receipt of this document and understand my rights and responsibilities
as a patient.

Patient Signature: _____Date:_____

SLEEP RITE
Notice of Privacy Practices Receipt
Medical Information Release and Assignment of Benefits

Patient Name _____ Patient DOB_____

Notice of Privacy Practices Receipt

We are required by law to maintain the privacy of, and provide with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the HIPPA Privacy Practices by this office, please ask to speak with our HIPPA Compliance Officer.

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim.
I hereby authorize SleepRite Center and staff to apply for benefits on my behalf for covered services rendered by the facility. I request that payment from my insurance be made directly to SleepRite Center. Our office will accept assignment of your insurance. However, it must be fully understood your insurance policy is a contract between you and your insurance company. Our office will not enter into dispute with your insurance company over policy limitation or issues. This is your responsibility and obligation. All charges incurred are your responsibility.
You will be responsible for your deductible, copay and coinsurance coverage not paid by your insurance. Payment is requested at the time of the service.
I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

_____ _____
Patients Signature Date

_____ _____
Witness Signature Date

SLEEP RITE
EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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 meeting)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____
TOTAL	_____

Name: _____ **DOB** _____

SLEEP RITE
BEDTIME QUESTIONNAIRE

Patient Name: _____ Date:_____

How long did you sleep last night? _____ hours

Did you take a nap today? _____ What time? _____ How long? _____

Prior to coming to the sleep center, has today been unusual in any way?

_____

_____

_____

Did you have any of the following today?

- ❑ Alcohol What time? _____ How much?_____
- ❑ Coffee What time?_____ How much?_____
- ❑ Tea What time?_____ How much?_____

What medications have you taken today?

Medication	**Amount**	**Time Taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any physical complaints right now? If yes, please explain:

_____

_____

_____

Usual bedtime: _____a.m./p.m. Usual wake time: _____a.m./p.m.