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

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.

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

AUTHORIZATION TO RELEASE INFORMATION

SLEEP RITE

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
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.

SLEEP RITE
SLEEP QUESTIONNAIRE

Patient Name: _____ DOB: _____Sex: **M / F** Age: ___Date:_____

Occupation: _____ Usual Work Hours/Days: _____

Referring Physician: _____ Family Physician (PCP): _____

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night How many months/years? _____

❑ Being sleepy all day How many months/years? _____

❑ Snoring How many months/years? _____

❑ Unwanted behaviors during sleep, explain _____

❑ Other, explain _____

Sleep Pattern	Work Days (Weekday)	Off Days(Weekends)
Typical bedtime:	_____ a.m./p.m.	_____a.m./p.m.
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_____	_____
Typical amount of time to fall back asleep after an awakening:	_____	_____
Typical wake up time:	_____ a.m./p.m.	_____a.m./p.m.
Desired wake up time:	_____ a.m./p.m.	_____a.m./p.m.
How do you usually awaken, i.e., alarm clock?:	_____	_____
Typical time you get out of bed:	_____ a.m./p.m.	_____a.m./p.m.
Total amount of sleep per night:	_____	_____
Number of naps per day:	_____	_____

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** _____

Name: _____Check all of the following statements that are true about your sleep:

Sleep Habits

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

Breathing

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

Restlessness

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

Daytime Sleepiness

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: _____cups/bottles/cans per day

Name: _____

Habits

Do you smoke? ❑ Yes ❑ No

If Yes: What?	Amount per Day	For How Many Years
❑Cigarettes	_____ pack(s)	_____ years
❑Cigars	_____ cigars	_____ years
❑Tobacco	_____ pipes	_____ years

Do you drink alcohol? ❑ Yes ❑ No

If Yes: What?	Frequency		AmountperWeek
❑Beer	❑Daily	❑Weekends	❑Rare _____cans/week
❑Wine	❑Daily	❑Weekends	❑Rare _____glasses/week
❑Liquor	❑Daily	❑Weekends	❑Rare _____shots/week

Social History

- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status: ❑Employed ❑Unemployed ❑Retired

- ❑ My job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker
- ❑ I am currently a student

Medical History

What is your: Height? ____ feet _____inches Weight? _____ pounds NeckSize:_____

What was your weight one year ago? _____ pounds Five years ago? _____ pounds

Current Medications

Medication Dose Times per Day

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

_____

Name: _____

Past Sleep Evaluation and Treatment

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or bilevel PAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder
- ❑ I have previously been treated for a sleep disorder

Past Medical History

- ❑ Hypertension (high blood pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach or colon problems
- ❑ Lung problems/COPD/asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or joint problems (arthritis)
- ❑ Cancer
- ❑ Thyroid problems
- ❑ Hepatitis/jaundice
- ❑ Hearing impairment
- ❑ Depression or severe anxiety
- ❑ Alcoholism
- ❑ Chemical dependency or abuse

Female

- ❑ Premenstrual syndrome
- ❑ Menopause

Male

- ❑ Prostate problems
- ❑ Erectile dysfunction/impotence

List other past medical problems and dates:

_____ _____

_____ _____

_____ _____

List Surgeries and the year

_____ _____

_____ _____

_____ _____