

# SLEEP CENTER OF KENTUCKIANA

7926 Preston Hwy. Suite 200
Louisville, KY 40219
Tel: (502) 964-2440
Fax: (866) 845-0491
www.KentuckySleep.com


## Patient Information

| First Name | MI | Last Name | Age | Date of Birth | Social Security # | Work |
|---|---|---|---|---|---|---|
| | | | | | | |

| Sex ☐ Male ☐ Female | Home Phone | Cell Phone | Next of Kin | Relation | Phone Number |
|---|---|---|---|---|---|
| | | | | | |

| Address | City | State | Zip Code | |
|---|---|---|---|---|
| | | | | |

| Employer | Employer Address | City | State | Zip Code | Employer Phone |
|---|---|---|---|---|---|
| | | | | | |

| Referring Physician | Primary Care Physician |
|---|---|
| | |

### RELEASE OF INFORMATION

I authorize the Sleep Center of Kentuckiana to release any patient medical information (including copies of record) needed for payment of this claim, quality assurance review, or to any physician involved in my care, hospital, and/or my insurance company including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical care.

### ASSIGNMENT OF BENEFITS

I authorize and request payments of insurance benefits directly to the Sleep Center of Kentuckiana otherwise payable to me. I have provided the Sleep Center of Kentuckiana a complete list of the insurance companies with which I have Medical coverage.

### CONSENT TO TREAT

I for my self the patient signed bellow, do hereby consent to and authorize the Sleep Center of Kentuckiana and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf.

### PHOTOGRAPHY / VIDEO / AUDIO CONSENT AND RELEASE

I hereby consent and authorize the Sleep Center of Kentuckiana and/or authorized persons employed by them to photograph, videotape, and, digital video recording with audio or film with audio for motion pictures any depiction or likeness of me or in which I may be included in whole or in part. I understand that this photo or video is necessary and integral part of my diagnostic procedure. Any such photograph, videotape, digital video, and audio will be kept as part of my medical record and will be released only pursuant to my consent or in accordance with other appropriate procedures for release of medical information.

### FINANCIAL AGREEMENT

Unless other arrangements have been made in advance by either you or your health coverage carrier, payment in full is due at the time of service. Acceptable methods of payment are cash, personal check, Visa, MasterCard, and Discover. There will be a $35 fee on any returned checks.

We are contracted providers with many health plans. We agree to submit a claim to your insurance plan, regardless of whether we have a contract with them. You are required to pay your plan authorized deductible and co-payment at the time of service. After the claim has been considered, we will bill you for any balance not previously paid.

Your insurance policy is a contract between you and your insurance company; your doctor is not involved. If you have questions or concerns regarding your plan's coverage on procedures, services, medications or particular conditions, you are responsible for obtaining this information prior to your appointment. You agree to pay in full for all services considered "non-covered" services per your insurance policy if you choose to have the service provided.

If your insurance company does not pay in consideration of the services provided, or you do not have insurance, you agree to pay all charges of the Sleep Center of Kentuckiana. Each bill is due upon presentation or mailing of a statement. Should the account become delinquent, you agree to pay all costs of collection, including interest applied by a collection agency and attorney fees.

_____ _____ _____

Signature of Patient or Guardian | Date | Guardian Relation

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## MEDICAL EMERGENCY TREATMENT

I understand that in the event of a medical emergency, EMS will be summoned and I will be transported to the nearest Emergency Room.

## PRIVACY PRACTICES

I understand that the Sleep Center of Kentuckiana may use and disclose my health information in order to:

1. Make decisions about, and plan for my care and treatment
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
3. determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care: and perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I also have the right to receive and review a written description of how the Sleep Center of Kentuckiana will handle health information about me.

I understand that I have read and understand the above information provided to me by the Sleep Center of Kentuckiana.

## Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and THE SLEEP CENTER OF KENTUCKIANA, LLC. Refer to as The Sleep Center.

- I consent to the use or disclosure of my protected health information by the sleep center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Sleep Center.
- I understand that analysis, diagnosis or treatment of me by The Sleep Center may be conditioned upon my consent as evidenced by my signature below.
- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Sleep Center is not required to agree to the restrictions that I may request. However, if The Sleep Center agrees to a restriction that I request, the restriction is binding on The Sleep Center. I have the right to revoke this consent, in writing, at any time, except to the extent that the sleep center has taken action in reliance on this Consent.
- My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.
- I have been provided with a copy of the HIPAA Notice of Privacy Practices (3/03) of the sleep center and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the sleep center. The Notice of Privacy Practices for the sleep center is also posted in the waiting room at 7926 Preston Hwy. Suite 200 Louisville, KY 40219. This Notice of Privacy Practices also describes my rights and duties of the sleep center with respect to my protected health information.

The Sleep Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of The Sleep Center and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative — Printed Name of Patient

_____ _____

Date of Signing — Description of Personal Representative's Authority

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## AUTHORIZATION TO RELEASE INFORMATION

NAME: _____Date of Birth_____PHONE#_____

| PLEASE ***OBTAIN*** INFORMATION ***FROM***: | | PLEASE ***SEND*** INFORMATION ***TO***: | |
|---|---|---|---|
| Name of Practice/Provider | | Name of Practice/Provider | |
| Address | | Address | |
| City, State, Zip | | City, State, Zip | |
| Phone | Fax | Phone | Fax |

I **AUTHORIZE** the following information to be disclosed:

- Entire Record
- Polysomnography
- CPAP Polysomnography
- Billing Records
- Doctor Consults
- Orders

*Please note that outside records in chart cannot be released to other facilities or patients without prior authorization. SCK (Sleep Center of Kentuckiana) record custodian is responsible for interoffice chart only.

**REASON** for disclosure

☐ At my request ☐ Job ☐ Continuation of Care ☐ School ☐ Legal ☐ Insurance ☐ Other

EXPIRATION of this Authorization to be 90 days from date of signature unless otherwise indicated below:

This Date_____

**ADDITIONAL PATIENT INFORMATION**:

*I understand that I do not have to sign this authorization in order to be treated

*I understand that I have the right to withdraw this authorization at any time (please sign below to withdraw)

*I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed and is no longer protected by SCK

*I understand that signing this authorization does not cancel any right I have under the other state or federal laws.

_____ _____ _____

Patient Signature (Legal Representative or Guardian, if applicable) Relationship/Authority Date

*I wish to withdraw this authorization: _____ Date: _____

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# Sleep Appointment Cancellation

Patient Name: _____

**Sleep Test Check-in time:** **9.00 PM.**

I understand that upon scheduling a sleep study appointment that a medical technician will be assigned to me on the night of my study.
I also understand that in case I would like to reschedule my appointment a 48 hour cancellation notice is required prior to my sleep study appointment.

All patients who fail to show up for their appointment without a **48 hours** cancellation notice will be charged and billed

## $200.00 dollars (Two Hundred Dollars).

We also might not be able to schedule your sleep study for several months. Please note that the usual wait time for a sleep study in the State of Kentucky is more than Six months.

_____ _____ _____
Signature of Patient or Guardian Date Guardian Relation

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## SLEEP QUESTIONNAIRE

| | | |
|---|---|---|
| Briefly describe the problems for which you are being referred to the sleep lab: | | |
| What prompted you to seek assistance (e.g., self-interest, urging of spouse, urging of employer, etc.)? | | |
| How long have you had your sleep problem? | ___ ☐ Weeks ☐ Months ☐ Years. | |
| **On weekdays:** | What time do you usually go to bed? | _____ ☐ a.m. ☐ p.m |
| | How long does it take you to fall asleep after deciding to go to sleep? | _____ Hours _____ Minutes |
| | What time do you usually get up? | _____ ☐ a.m. ☐ p.m |
| | Do you take naps? | ☐ YES ☐ NO |
| **How many NAPS** _____ How long _____<br>What is the total number of sleep hours you usually get at night?_____ Hours _____ minutes<br>How long is the typically longest period of wakefulness?_____ Hours _____ Minutes<br>How many times do you get out of bed during a typical night of sleep? __ | | |
| **Off work days:** | What time do you usually go to bed? | _____ ☐ a.m. ☐ p.m. |
| | What time do you usually get up? | _____ ☐ a.m. ☐ p.m. |
| | Do you take naps | ☐ YES ☐ NO |
| **How many NAPS** _____ How long _____ | | |

| When falling asleep, how often do you: | NEVER | SELDOM | SOMETIME | OFTEN | USUALLY |
|---|---|---|---|---|---|
| Have thoughts racing through you mind? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feel depressed? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feel anxious or depressed? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Worry about not being able to sleep? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feel unable to move? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Experience vivid dream-like scenes even though you know you are awake? | ☐ | ☐ | ☐ | ☐ | ☐ |
| Experience any kind of pain or discomfort? | ☐ | ☐ | ☐ | ☐ | ☐ |

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| When falling asleep, how often do you: | YES | NO |
|---|---|---|
| Do you have a fear of not being able to go to sleep once you have awakened during the night? | ☐ | ☐ |
| Do you have disturbed restless sleep? | ☐ | ☐ |
| Do you disturb the sleep of your bed partner? | ☐ | ☐ |
| Do you snore in any way? | ☐ | ☐ |
| Do you suddenly awaken gasping for breath? | ☐ | ☐ |
| Do you sweat excessively during the night? | ☐ | ☐ |
| Do you fall out of bed while asleep? | ☐ | ☐ |
| Do your legs twitch or kick while you are asleep? | ☐ | ☐ |
| Do you have a full night of intense, vivid dreams? | ☐ | ☐ |
| Do you have nightmares? | ☐ | ☐ |
| Do you depend on an alarm clock to awaken you? | ☐ | ☐ |
| Do you notice that you are unusually difficult to awaken in the morning? | ☐ | ☐ |
| Do you awaken with a morning headache? | ☐ | ☐ |
| Do you feel extremely alert and energetic during the entire day? | ☐ | ☐ |
| Do you ever have episodes of sudden muscular weakness when laughing, angry, or are in other emotional situations? | ☐ | ☐ |
| Has anyone in your family had seizures, fainting, dizziness or black-out spells? | ☐ | ☐ |
| Can you breathe easily through your nose? | ☐ | ☐ |
| Do you take any type of medicine at present to help you go to sleep? | ☐ | ☐ |

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How many times have you ever been involved automobile accident? __

How many times have your accidents been caused by sleepiness? __

Do you smoke? ☐ YES ☐ NO If YES how many packs a day? _

Do you drink Alcohol ☐ YES ☐ NO If YES how often? _

Illicit Drugs? ☐ YES ☐ NO

When was your last check-up / Physical? _____

## How much of the following fluids do you drink?

| Fluids | During a typical 24 hour period | Within 2 hours of going to sleep |
|---|---|---|
| A- COFFEE | CUPS | CUPS |
| B- TEA | CUPS | CUPS |
| C- COLA DRINKS | CANS | CANS |

## Please list below your past medical history:

| Previous illness | **Approximate year of onset** |
|---|---|
| | |
| | |
| | |
| | |

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**Please list below previous surgical history:**

| Type of injury | Approximate year of injury |
|---|---|
| | |
| | |
| | |

**Please list below any medications you are currently taking:**

| Medication | Dose / Frequency | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please list below any other non-prescribed or street drugs (e.g., marijuana) you are currently taking or have taken in the past five years:**

| Name | Dates |
|---|---|
| | m/d/yyyy |
| | m/d/yyyy |

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# SLEEPINESS SCALE

How likely are you to dose off or fall asleep in the following situations in contrast to just feeling tired?
This refers to your usual way of life in recent times, even if you have not done some of these things recently; try to work out how they would have affected you.
Use the following scale to choose 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.

| SITUATION | CHANCE OF DOZING | | | |
|---|---|---|---|---|
| Sitting and reading | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Watching TV. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sitting inactive in a public place (ege., a theater or a 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 when circumstances permit | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sitting quietly after a lunch without alcohol | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sitting and talking to someone | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| In a car while stopped for a few minutes in traffic | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

**Total Points = ____**

PATIENT'S SIGNATURE: _____ Date _____ m/d/yyyy

**THANK YOU FOR YOUR COOPERATION**

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# Fatigue, Sleepiness and Driving

PATIENT NAME: _____ Date of Birth_____

Excessive fatigue and sleepiness can be the result of a number of factors: sleep deprivation, shift work or a sleep disorder can contribute greatly to your inability to remain alert and attentive behind the wheel of a motor vehicle.

The National Highway Traffic Safety Administration estimates that there are a minimum of 100,000 crashes and 1,500 deaths annually as a direct result of driver fatigue. They also report that drowsiness plays a role in another 1 million crashes caused by driver inattention.

In addition, the National Sleep Foundation states that in an annual poll of adults ages 18-54, 60% of respondents report driving while feeling drowsy.

With this information in mind, we feel it is our responsibility to advise each of our patients with symptoms of fatigue and daytime sleepiness of the need to remain alert while driving. If sleepiness is so intense that it impairs the ability to drive safety, we advise that driving be avoided altogether until diagnosis and treatment has eliminated sleepiness.

Please acknowledge that you have been advised of this information with your signature below.

Signature: _____ Date: _____