Capitol Sleep Medicine

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Patient Information

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (__) _____ Cell Phone: (___)_____

Email Address: _____

Birthdate: _____/_____/_____ Age: _____ SSN: _____

Gender: □ Male □ Female Marital Status: _____

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Native Hawaiian/Other Pacific Islander

□ White □ Other □ Refuse to Report

Ethnicity: □ Hispanic/Latin □ Non-Hispanic/Latin □ Refuse to Report

Preferred Language: _____

Name of Your Primary Care Physician: _____ Telephone: (___) _____

Who Referred You to Us? Physician's Name: _____ Specialty: _____

Name of your Spouse or Parent (if patient is a minor): _____

Contact telephone number for Spouse/Parent: (___) _____

Employer Information

Name of Patient's Employer: _____ Phone: (___) _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact

Last Name: _____ First Name: _____ Relationship to Patient: _____

Emergency Contact's telephone numbers:

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___)

May we release Protected Health Information to your emergency contact? □ Yes □ No

Insurance Information □ Self Pay (No Insurance)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber ID Number: _____ Group Number:_____

Subscriber's Relationship to Patient: _____

Subscriber's Birthdate:_____ Subscriber's SSN: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber ID Number: _____ Group Number: _____

Subscriber's Relationship to Patient: _____

Subscriber's Birthdate: _____ Subscriber's SSN: _____

I am responsible for providing up-to-date and accurate insurance information to Capitol Sleep Medicine, LLC. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) or under the terms of any other insurance carriers is correct. If my insurance changes I will notify Capitol Sleep medicine LLC within 10 days of this change. I understand that failure to do so may result in me being billed for any outstanding balances.

I hereby authorize Capitol Sleep Medicine, LLC and/or any of its representatives to submit claims to my insurance carrier or its intermediary for services rendered to me by Capitol Sleep Medicine, LLC and authorize payment be made directly to Capitol Sleep Medicine, LLC. I hereby authorize the release of any information necessary to process medical claims. I authorize release of medical information necessary for continuity of care to Home Medical Equipment companies as recommended by my medical provider.

I understand that my insurance carrier can choose to assign benefits to Capitol Sleep Medicine, LLC. I understand and certify I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier as well as for any applicable co-payments, co-insurance, deductibles and/or charges for non-covered goods and services provided to me or to any of my dependents.

I will pay any and all charges due and owing Capitol Sleep Medicine, LLC in accordance with their regular rates, terms and policies.

By signing below, I certify I will pay to Capitol Sleep Medicine, LLC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to Capitol Sleep Medicine, LLC any payments that I receive from my insurance carrier for goods and services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance for my failure to provide the appropriate insurance information for billing.

_____ Date: _____/_____/_____

Signature of Patient (or Parent, if Patient is a Minor)

FINANCIAL/OFFICE POLICIES

Thank you for the opportunity for Capitol Sleep Medicine, LLC to participate in your health care. We are committed to providing quality service.

1. It is your responsibility to provide us with up-to-date and accurate insurance information. In addition to your health insurance card, we may ask for a photo ID. You will be responsible for any amounts not paid by insurance because you have not provided the appropriate insurance information to Capitol Sleep Medicine, LLC.

2. You must complete and sign any required information sheets and/or payment agreement forms before receiving service from Capitol Sleep Medicine, LLC.

3. It is your responsibility to understand your insurance benefits, obtain proper authorizations for services and submit referral claim forms if necessary.

4. Many insurance plans require patients to pay a co-payment, deductible or co-insurance amount. It is your responsibility to understand any applicable co-payments, deductibles, and co-insurances. Please come to your appointment prepared to pay your co-payment.

5. If you have no insurance or Capitol Sleep Medicine, LLC does not participate in your insurance plan, payment in full is required prior receiving services.

6. Insurance benefits are the result of your contract with your insurance company. If your insurance plan does not pay our bill within sixty (60) days after billing, or your claim is denied, you will receive a statement from Capitol Sleep Medicine, LLC indicating the bill is now your responsibility. Patient balances are billed upon receipt of your insurance plan's explanation of benefit (EOB). Your payment is due within ten (10) business days of your receipt of our bill.

7. Capitol Sleep Medicine, LLC requires at least forty-eight (48) hours' notice for canceling for a sleep study appointment. Failure to provide timely notice of cancellation for a sleep study may result in a cancellation fee of $150.00.

8. Security is a priority for Capitol Sleep Medicine, LLC. We have a security system for the building as well as security cameras monitoring the parking lots. Nevertheless, theft or damage to your personal property may occur. Capitol Sleep Medicine, LLC claims no responsibility for loss or damage to personal property, and you hereby release Capitol Sleep Medicine, LLC from any and all claims from liability for any loss or damage to personal property that occurs on our premises.

9. If you take any medications you should check with your physician as to whether you should take them on the day of your study. If the physician has given you a prescription for a sleep aid, please bring that medication with you. The sleep technicians do not dispense medications to patients. **Please be aware that medications you may take to help you sleep in the sleep lab may cause drowsiness, and in this case it is your responsibility to arrange for a ride home after your study.**

I AGREE TO COMPLY FULLY WITH ALL POLICIES AS DETAILED ABOVE.

Signed: _____ **Date:** _____

Print Name: _____

Medical History Form

Name_____ Date_____

Instructions: Please check the boxes below that pertain to your past medical history:

____Obstructive Sleep Apnea
____Insomnia
____Restless Legs Syndrome
____Multiple Sclerosis
____Migraine Headaches
____Movement Disorder (e.g. Parkinson's Disease)
____Dementia
____Depression
____Seizures, convulsions, epilepsy
____Stroke
____Asthma
____Emphysema/chronic bronchitis/COPD
____Cardiac rhythm disturbances
____Pneumonia
____Pulmonary fibrosis
____Scoliosis/kyphoscoliosis
____Angina pectoris/coronary disease
____Heart failure

____Deviated nasal septum
____Nasal polyps
____Sinusitis, sinus condition
____Still have tonsils/adenoids
____Goiter/neck mass
____Problems with vocal cords
____Diabetes and taking insulin
____Hypoglycemia (low blood sugar)
____Hypothyroidism (under active thyroid
____Hyperthyroidism (over active thyroid)
____Pancreatitis
____Pituitary/hypothalamic disorders
____B12 deficiency
____Esophagitis/heatburn/hiatal hernia/ulcer
____Hepatitis or cirrhosis of liver
____Irritable bowel syndrome
____Heart attack
____High blood pressure

Medications

Name_____ Date_____

Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:

_____ _____
_____ _____
_____ _____
_____ _____

Medical History Form

Name_____ Date_____

Diagnostic Tests performed in the past

Directions: Please fill in all that apply as completely as possible. This information may prevent unnecessary duplication of diagnostic studies. If you have not had a particular test, leave the space blank.

Test	Month/year	Where	Results
All night sleep study			
Multiple Sleep Latency Test			
Maintenance of Wakefulness Test (MWT)			

Name_____ Date_____

Epworth Sleepiness Scale

How likely are you to doze 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**			
	Never	Slight	Moderate	High
Sitting and reading…….	0	1	2	3
Watching television…….	0	1	2	3
Sitting inactive, in a public place, e.g. in a meeting…	0	1	2	3
As a passenger in a car for an hour without a break…	0	1	2	3
Lying down in the afternoon when circumstances permit…	0	1	2	3
Sitting and talking to someone…	0	1	2	3
Sitting quietly after lunch without alcohol…	0	1	2	3
In a car while stopped for a few minutes in traffic…	0	1	2	3

Total Score _____

HIPAA / ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

By signing the following you are giving Capitol Sleep Medicine, LLC permission to use and disclose your protected health information in accordance with the directives listed below:
I _____ on this date _____ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health care information for directory purpose.
- The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations.

Signature_____

Date _____