



Patient Information

Last Name: _____ **First Name:** _____ **Middle initial:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone-home: _____ **Work/Cell:** _____

Sex: _____ **Marital Status:** _____ **S.S.N.:** _____

Employer: _____ **DOB:** _____ **Age:** _____

Referring Physician: _____ **Referring Physician Phone Number:** _____

Primary Care Physician: _____ **Primary Care Phone:** _____

Spouse or Parent (if minor) _____ **Relationship** _____

Contact telephone number _____ **Email address** _____

Please circle:

Do you operate a motor vehicle for your occupation? Yes No

Patient Signature _____ **Date** _____

Insurance Information

Insurance Company (Primary) _____ **Subscriber ID:** _____

Group Number: _____ **Relation to Insured:** _____

Insured Name: _____ **DOB:** _____ **S.S.N.** _____

Insurance Company (Secondary) _____ **Subscriber ID:** _____

Group Number: _____ **Relation to Insured:** _____

Insured Name: _____ **DOB:** _____ **S.S.N.** _____

I request that payment of authorized benefits be made either to me or on my behalf to the above provider for services furnished by that physician. I authorize release to the indicated insurance carrier any medical information about me needed to determine these payments for related services.

Signature: _____

Date: _____



MEDICAL HISTORY FORM

Patient Name (Last, First, MI) _____ Date _____

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

- | | |
|---|--|
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Deviated nasal septum |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Nasal polyps |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Sinusitis, sinus condition |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Still have tonsils/adenoids |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Goiter / neck mass |
| <input type="checkbox"/> Movement disorders (ex. = Parkinson's) | <input type="checkbox"/> Problems with vocal cords/ "voice box" |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Diabetes and taking insulin |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes and not taking insulin |
| <input type="checkbox"/> Psychiatric illness | <input type="checkbox"/> Hypoglycemia (low blood sugar) |
| <input type="checkbox"/> Seizures, convulsions, epilepsy | <input type="checkbox"/> Hypothyroidism (under active thyroid) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hyperthyroidism (overactive thyroid) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Emphysema/chronic bronchitis/COPD | <input type="checkbox"/> Pituitary/hypothalamic disorders |
| <input type="checkbox"/> Occupational (black lung, silicosis) | <input type="checkbox"/> B12 deficiency |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Esophagitis/heartburn/hiatus hernia/ulcer |
| <input type="checkbox"/> Pulmonary fibrosis | <input type="checkbox"/> Hepatitis or cirrhosis of liver |
| <input type="checkbox"/> Scoliosis/kyphoscoliosis | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Angina/coronary disease | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Cor pulmonale (right heart strain) | <input type="checkbox"/> Heart failure |
| <input type="checkbox"/> High blood pressure | Other: _____ |
| <input type="checkbox"/> Cardiac rhythm disturbances | |



MEDICAL HISTORY FORM

Patient Name (Last, First, MI) _____ Date _____

Present Medications

<u>Medication</u>	<u>Dosage per day</u>	<u>For how long</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



MEDICAL HISTORY FORM

Patient Name (Last, First, MI) _____ 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.

<u>Test</u>	<u>Month/Year</u>	<u>Where done</u>	<u>Results</u>
Chest X-Ray	_____	_____	_____
Electrocardiogram (EKG)	_____	_____	_____
CT Scan	_____	_____	_____
Brain MRI Scan	_____	_____	_____
Carotid Ultrasound	_____	_____	_____
Carotid Doppler	_____	_____	_____
Echocardiogram	_____	_____	_____
All-night sleep study	_____	_____	_____
Multiple Sleep Latency Test (MSLT)	_____	_____	_____
Maintenance of Wakefulness Test (MWT)	_____	_____	_____



Epworth Sleepiness Scale

Patient Name (Last, First) _____ Date _____

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 _____



FINANCIAL POLICY

Thank you for the opportunity to participate in your health care.

1. It is your responsibility to have provided us with your full health coverage information: (including written confirmation of any required preauthorization or verification of current coverage / detailed billing information / any changes in insurance or coverage). Patient must have completed and signed any required information sheets and/or payment agreement forms before seeing the doctor or receiving service from our practice.
2. It is your responsibility to understand any deductibles and copays that you may have as dictated by your third party payor and the health insurance plan that you hold.
3. Payment in full. "participating provider" and credit policies:
 - Payment in full is to be made by patient or responsible party, parent or guardian at time of service-unless we are participating providers in your / the patient's health plan and have received any necessary preauthorization(s) in advance of your health services. In this case, any co-pays/deductibles must be made at the time of service.
 - Charges for the performance, interpretation and reporting of sleep studies: Payment in full of any outstanding balance for such service is to be made personally by the patient (or responsible parent or guardian) within sixty days of performance of the services, unless we are participating providers in your health plan and have received appropriate advance preauthorization. In this case, co-pay/deductible amounts must be paid by the patient or responsible party (i.e. parent or guardian) within sixty says of service.
4. THIRD PARTY PAYOR CONTRACTUAL LEGAL CONSTRAINTS PROHIBIT PHYSICIANS FROM "FORGIVING"/NOT SEEKING TO COLLECT DEDUCTIBLES/CO-PAYS THEY ARE OWED BY THEIR PATIENTS. Violation of these legal constraints can put your physician in jeopardy of violating third party payor contracts and thus make you financially responsible for the entire payment of your health services.
5. All patients are required to give at least a 48 hour notice if canceling for a sleep study appointment. Failure to cancel within the 48 hour period will result in a cancellation fee of \$150.00. Capitol Sleep Medicine recognizes that extenuating circumstances may keep you from canceling within the appropriate time period and it is within the discretion of the practice to forgive this fee.

I AGREE TO COMPLY FULLY WITH ALL TERMS OF THE FINANCIAL POLICY AS DETAILED ABOVE.

Signed _____ Date _____



HIPAA / HEALTH CARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES Capitol Sleep Medicine LLC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Capitol Sleep Medicine LLC to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

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 above

ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES

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

Signed _____ Date _____