Capitol Sleep Medicine

Patient Information

Patient Name_____ **Date_____**

Address:_____

City:_____ State:_____Zip:_____

Phone-home:_____ Work:_____Cell:_____

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

Employer:_____DOB:_____ Age:_____

Race: [ ] American Indian / Alaskan Native [ ] Asian [ ] Black / African American

[ ] Native Hawaiian / Pacific Islander [ ] White [ ] Refuse to Report

Ethnicity: [ ] Hispanic / Latin [ ] Non Hispanic / Latin [ ] Refuse to Report

Preferred Language:_____

Referring Physician _____Referring Physician Phone_____

Primary Care Physician:_____Primary Care Phone: _____

Spouse or Parent (if minor) _____ Relationship_____

Contact telephone number _____ Email address _____

Preferred Pharmacy Name_____Location_____

Employer Information

Name of Patient's Employer_____ Telphone (___) ____-_____

Employer's Address_____City_____State____Zip_____

Emergency Contact

Last Name_____First Name_____Relationship to patient_____

Emergency Contact's Telephone Numbers:

Patient Name_____ **Date_____**

Home (___) ____-_____ Work (___) ___-_____ Cell (___) ___-_____

May we release Protected Health Information to your Emergency Contact? [ ] Yes [ ] No _____Initial

<if:patient_name_lf ^ endif>

Insurance Information: [ ] Self Pay (No Insurance)

Insurance Company (Primary) _____Subscriber ID:_____

Group Number:_____ Relation to Insured:_____

Subsciber Name:_____DOB:_____S.S.N._____

Insurance Company (Secondary) _____Subscriber ID:_____

Group Number:_____ Relation to Insured:_____

Subsciber Name:_____DOB:_____S.S.N._____

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 your insurance changes I will notify Capitol Sleep Medicine 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 and authorize payment be made directly to Capitol Sleep Medicine, LLC. I hereby authorize 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 will assign benefits to Capitol Sleep Medicine, LLC. I understand and certify that 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 copayments, coinsurance, 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 that I will pay to Capitol Sleep Medicine, LLC any copayments, coinsurance, deductibles, or non covered goods and services. I will immediately pay to Capitol Sleep Medicine, LLC any payments I receive from my insurance for services provided by them to me or my dependents. I will also be responsible for any amounts not paid by my insurance due to my failure to provide Capitol Sleep Medicine, LLC appropriate insurance information for billing.

Patient Signature_____ Date_____

Patient Name_____ **Date_____**

MEDICAL HISTORY FORM

CARDIOVASCULAR

_____ Angina/coronary disease

_____ Cardiac Rhythm disturbance

_____ Heart attack

_____ Heart failure

_____ High blood pressure

_____ Stroke

ENDOCRINE

____ Diabetes and taking insulin

_____ Diabetes and not taking insulin

_____ Goiter / neck

_____ Hypoglycemia (low blood sugar

_____ Hyperthyroidism (overactive thyroid

_____ Hypothyroidism (under active thyroid)

_____ Pancreatitis

_____ Pituitary/hypothalamic disorder

GASTROENTEROLOGY

_____ Esophagitis/heartburn/hiatus hernia/ulcer

_____ Irritable bowel syndrome

HEENT

_____ Deviated nasal septum

_____ Nasal polyps

INFECTIOUS DISEASE

___ Pneumonia

MUSCULOSKELETAL

____ Restless Legs Syndrome

____Scoliosis/ kyphoscoliosis

NEUROLOGY

____Migraine headaches

____ Seizures, convulsions

____Multiple Sclerosis

PSYCHIATRY

_____ Insomnia

____ Dementia

_____ Depression

____ Psychiatric illness

RESPIRATORY

_____ Obstructive Sleep Apnea

_____ Asthma

____ Emphysema/chronic bronchitis/COPD

_____ Pulmonary fibrosis

HEMATOLOY/LYMPHATIC

_____ B12 Deficiency

SURGICAL HISTORY:___Tonillectomy_____Surgery for OSA_____

Patient Name_____ **Date_____**

Medications:

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

Medication Allergies:

_____	_____	_____
_____	_____	_____

Patient Name_____ **Date_____**

Any Daytime Sleepiness?_____ If yes Mild?_____ Moderate?_____ Severe?____

Night Sweats? _____

Any changes in your weight in the last year more then 15 LBS?

Is it weight gain?____ weight loss?_____ how much?_____

Any frequent headaches?

Tension?____ Migraine?____

Vision affected by headache?_____ if yes any Nausea?_____ Vomiting?_____

Sinus problems?_____

Any Shortness of breath? _____

Coughing?_____ Wheezing?_____

Chest Pain?_____

Heart palpitation/ irregular heart beat?_____

Frequent urination more than 3 times a night?____

Any arthritis/ backaches?_____

Numbness/tingling in arms or legs?_____

Depression?_____

Anxiety?_____

Irritability?_____

Problems with insomnia?_____

MEDICAL HISTORY FORM

Patient 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 (MSLT)			
Maintenance of Wakefulness Test (MWT)			

Patient 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 _____

Patient Name_____ **Date_____**

FINANCIAL/OFFICE POLICIES

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

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

2. You must complete and sign any required information sheets and/or payment agreement forms before seeing the doctor or receiving service from our practice.

3. It is your responsibility to understand your insurance benefits, obtaining proper authorization 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, co-insurances, and deductibles. Please come to your appointment prepared to pay your co-payment.

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

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

7. Capitol Sleep Medicine, LLC requires at least forty eight (48) hours notice for cancelling 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. Checks written to Capitol Sleep Medicine that are returned by your bank due to insufficient funds will incur a $50 penalty.

Other Items:

1. Security is a priority for Capitol Sleep Medicine, LLC. We have a security system for our building. At the Grove City location we have security cameras as well monitoring the parking lots. Nevertheless, it is possible that theft or damage to your personal property may occur while parking on our property. Capitol Sleep Medicine claims no responsibility for loss or damage to personal property while parked in our parking lots. You hereby release Capitol Sleep Medicine LLC from any and all claims from liability from any loss or damage to personal property that occurs on our premises.

2. 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 this 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_____

Patient Name_____ **Date_____**

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

Signed_____ **Date_____**