sleep solutions

Patient Name:_____Date of Birth:____/____/____

SSN_____Gender__M F__Marital Status_____Student(part/full time)___

Home Address_____

Mailing Address(if different from above)_____

City_____State_____Zip_____

Home_____Work Phone_____Cell_____

Employer_____Occupation_____

Emergency Contact_____Phone_____

Is Patient the insurance Policy Holder? Yes No

Primary Insurance_____Name of Policy Holder_____

Policy Holder Date of Birth__/__/____ Policy Holder SSN_____

Policy Holder Home Address(if different from above)

_____City_____State_____Zip_____

Home Phone_____Work Phone_____Cell_____

_____

Primary Insurance:_____Insured Name:_____

Insurance Company Address:_____City:_____State:__

ID#_____Group#_____Phone:_____

Secondary Insurance:_____ Insured Name:_____

Insurance Company Address:_____City:_____State:__

ID#_____Group#_____Phone:_____

Who referred you to Sleep Solutions?_____

I understand that having insurance coverage does not release me of this liability
I hereby authorize the following:

1. Release of any information to obtain medical examination treatment and/or payment(assignment of benefits to be valid until revoked by me in writing.)
2. Direct payment of benefits to Sleep Solutions.
3. Photocopies of this form to be valid as original.

Patient/Guardian Signature:_____Date_____

BRING THIS COMPLETED FORM WITH YOU ON THE NIGHT OF YOUR SLEEP STUDY

Sleep Questionnaire

Name: _____ **Date:** _____
(Last) (First) (Middle)

Height:_____ **Weight:**_____ **Age:**_____ **Sex:** __ **Male** __ **Female**

Chief Complaints

What are your major complaints related to sleep and wakefulness and how long have you experienced them?

1. _____ 3. _____

2. _____ 4. _____

I. Epworth Sleepiness Scale

1. Are you excessively sleepy during the day? __ Yes __ No

2. Use the following Scale to choose the most appropriate number of each situation:

0= would never
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

a. Sitting and reading _____
b. Watching TV _____
c. Sitting inactive in a public place _____
d. As a passenger in a car for an hour without a break _____
e. Lying down to rest in the afternoon when circumstances permit _____
f. Sitting and talking to someone _____
g. Sitting quietly after lunch w/o alcohol _____
h. In a car, while stopped for a few minutes in traffic _____

TOTAL _____

II. Symptoms During Sleep

1. Check off any of the following symptoms that you currently have when you sleep or are trying to sleep.

__ Toss & Turn
__ Heartburn
__ Regurgitation
__ Cold Feet
__ Nightmares
__ Fall Out Of Bed
__ Sour Belches
__ Irresistible urge to move legs
__ Night Sweats
__ Sleep Walking
__ Bed Wetting
__ Pain
__ Teeth Grinding
__ Sleep Talking
__ Legs Jerking

2. Check off any of the following that you have experienced during sleep:

__ Struggling to breathe
__ Loud Snoring
__ Sleeping w/mouth open
__ Waking w/dry mouth
__ Making whistling sounds
__ Waking yourself w/snoring
__ Choking
__Gasping for air
__ Stop breathing
__ Snorting
__ Non-restorative sleep

3. Do you snore in all positions? __ Yes __No
If not, which: _____

What is your normal bedtime?_____What is your normal wake time?_____

III. Narcolepsy

1. As you fall asleep or wake up, do you have vivid or life-like visions? __ Yes __ No

2. When you are angry or excited, do you have a sudden weakness or does any part of your body go limp. (head drop, Knees buckle, etc.) __ Yes __No

3. As you are trying to go to sleep or wake up, do you ever experience an inability to move? __Yes __No

4. Have you ever driven or traveled somewhere and not remembered how you got there? __ Yes __ No

IV. Treatment

Have you ever been treated for a sleep problem?
__ Yes __ No If yes, explain:
_____
_____
_____
_____

V. Psychological

Check off any of the following symptoms that apply to you.

__ Anxiety
__ Fatigue
__ Change in personality
__ Depression
__ Inability to concentrate
__ Family problems
__ Irritability
__ Loss of appetite
__Memory impairment
__ Suicidal thoughts

VI. Review of Symptoms

Check off any of the following symptoms that apply to you.

__ High blood pressure
__ Chest pain
__ Cough
__ Dry throat
__ Frequent urination
__ Shortness of breath
__ Heartburn
__ Headache
__ Indigestion
__ Sinus trouble
__ Sore Throat
__ Sour belches
__ Swelling of legs
__ Wheezing

List any other symptoms you may have not listed above.
_____
_____

VII. Social and Family History

1. Do you smoke? __ Yes __ No How long?_____ How many?_____

2. Do you drink alcohol? __ Yes __ No How much?_____

3. Do you drink alcohol to help you fall asleep at bedtime? __ Yes __ No

4. Daily caffeine intake is: _____ cups of coffee _____colas _____ tea/iced tea

5. What do you do at work?_____

6. What are your working hours?_____

7. How many people live in your home?_____ Relationship:_____

8. How many bedrooms do you have?_____ Does your bedroom have a TV? __ Yes __ No

9. Does any family member have a sleep problem or snore loudly? __ Yes __ No

VIII. Medications

List below all medications you currently take:
_____
_____
_____
_____

Pre-Sleep Questionnaire

Name:_____ **Date:**_____
(Last) (First)

Height:_____ **Weight:**_____ **Age:**_____ **Sex:** __ **Male** __ **Female**

1. Did you have a normal night's sleep last night? ___**Yes** ___ **No.** **If no, explain.**

_____

_____

2. Did you take any naps today? ___ **Yes** ___ **No** **If yes, what time?**_____ **How long?**_____

3. Have you had any of the following today?

a. Alcohol ___**Yes** ___ **No.** **If yes, how much?** _____ **When?** _____

b. Coffee or Tea ___**Yes** ___ **No.** **If yes, how much?** _____ **When?** _____

c. Cola ___**Yes** ___ **No.** **If yes, how much?** _____ **When?** _____

4. Please describe anything else that occurred last night or today that might affect your sleep tonight?

_____

_____

5. Please list any medications you have taken today.

_____

_____

_____

BRING THIS COMPLETED FORM WITH YOU ON THE NIGHT OF YOUR SLEEP STUDY

Observation/Sleep Partner Questionnaire

Sleep partner signature_____****

(your signature and the information you provide is relevant to the diagnosis and care of this patient; it is also proof to the insurance provider that these symptoms are witnessed)

Patient Name: _____ Date Of Birth: _____

1) I Have Observed The Above Patient's Sleep:

_____ Often _____ Occasionally _____Every Night

2) Please Check Any Of The Following Behaviors That You Have Observed During The Course Of The Patient's Sleep:

____ Light Snoring
____ Choking
____ Grinding Teeth
____ Morning Headaches
____ Bed Wetting
____ Head Rocking Or Banging
____ Loud Snoring
____ Biting Tongue
____ Sleep Walking
____ Crying Out
____ Sitting Up Still Asleep
____ Becoming Rigid And/ Or Shaking
____ Occasional Loud Snorts
____ Pauses In Breathing
____ Twitching Leg(s)
____ Getting Up Still Asleep

3) Please Describe The Behaviors Checked Above In More Detail. Include A Description Of The Activity, The Time During The Night It Typically Occurs, Its Frequency, Whether It Occurs Every Night:

_____
_____
_____
_____
_____
_____

4) Has The Patient Ever Fallen Asleep During Normal Daytime Activities Or In Dangerous Situations? If So, Please Describe Below:

_____
_____
_____
_____
_____
_____

SLEEP STUDY INFORMED CONSENT FORM

A sleep study or polysomnogram (PSG) is an overnight test during which several physiologic functions are monitored. These include brain activity, eye movements, muscle tone, heart rhythm, airflow from the nose and mouth, breathing effort, blood oxygen levels and leg movements. Attaching small gold electrodes to the surface of the scalp or skin monitors most of these functions. The skin is not punctured.

Six (6) electrodes attached to the scalp monitor brain activity. The electrodes are attached with paste which is easily removed in the morning. The patient's brain activity is monitored to determine if, during the course of the sleep study, the patient is asleep or awake and to determine the patient's then-current sleep stage(s).

The patient's eye movements are measured by placing snap electrodes near the outer edge of each eye. Eye movements are measured to determine if the patient is in the stage of sleep where vivid dreaming occurs (rapid eye movement sleep). Removing the electrodes in the morning may be mildly uncomfortable.

Muscle tone is measured by placing two (2) electrodes—both are placed on the patient's chin. Muscle tone is also measured to help determine if the patient is in rapid eye movement sleep.

Heart rhythm is measured by placing two (2) electrodes on the chest.

Airflow from the nose and mouth are measured by taping a small device called a thermistor beneath the nose. Airflow is measured to determine if the patient is experiencing sleep apnea/hypopnea syndrome. This is a disorder in which there are either pauses in airflow (apnea) or reductions in airflow (hypopnea) during sleep due to obstruction of the upper airway.

Breathing effort is measured by placing elastic belts around the chest and abdomen. These electrodes are placed over the pajamas and help to determine the type of breathing problems that are occurring.

Blood oxygen level is measured by placing a small device on the finger. This device shines a small red light into the finger and is completely painless.

Leg movements are measured by placing two (2) electrodes on each leg. Leg movements are measured to determine if the patient has a disorder in which the legs twitch repeatedly throughout the night (periodic limb movement disorder).

Each patient bedroom has a television and a comfortable bed. Electrode attachment takes about an hour. Usually two (2) patients undergo sleep studies each night (each patient has a private room). A patient will go to be with lights out between 10:00 p.m. and 11:00 p.m. Lights on time is usually around 6:00 a.m.

After the electrodes are attached, the electrode wires are wrapped into a bundle to prevent tangling. All the wires plug into a small box that is connected to recording equipment in a nearby control room. If the patient needs to visit the restroom during the night, the box can be unplugged and carried into the resttroom.

It takes about five (5) minutes to disconnect all the electrodes in the morning.

Continuous positive airway pressure (or CPAP) may also be used during the patient's sleep study. A CPAP machine is a device that delivers room air through a hose and into a mask that is worn over the nose. The nasal mask is kept in place by elastic headgear. The incoming air helps to prevent the upper airway from collapsing, thereby eliminating the breathing pauses that are occurring in sleep apnea syndrome.

There are no known side effects (or material risks) associated with the performance of a sleep study.

Sleep Solutions is required to disclose or report certain medical diagnosis information to local health departments or the Center for Disease Control and Prevention. Reportable information includes cases of HIV, tuberculosis, viral meningitis and certain other diseases.

I understand that, once the sleep study is commenced, a patient may terminate the sleep study at any time.

I AGREE TO UNDERGO THE SLEEP STUDY AS ORDERED BY MY PHYSICIAN

_____
Patient Signature

_____
Print Patient Name

_____
Date

_____
Direct Patient Care Provider—Witness Signature

_____
Direct Patient Care Provider—Witness Print Name

BRING THIS COMPLETED FORM WITH YOU ON THE NIGHT OF YOUR SLEEP STUDY

Patient Authorizations And Financial Terms

1) Patient's physician has requested that Sleep Solutions perform a sleep study(s) on Patient and, if medically necessary, furnish Patient with a C-PAP machine in order to diagnose and treat sleep apnea and other sleep-related disorders. Patient consents to the performance of these services.

2) Sleep Solutions will obtain, on Patient's behalf, any required third party payor authorization(s) and bill all third party payors directly for all services Patient receives.

3) **As a condition of receiving care, Patient is required to pay all deductible and coinsurance amounts in advance of receiving care**.

4) Patient authorizes Sleep Solutions to provide protected health information to a third party payor (or its designee) as necessary for Sleep Solutions to be reimbursed for healthcare services provided to Patient.

5) Patient agrees that he/she will be responsible for the payment of Sleep Solutions' charges if, for any reason, patient's insurer or payor fails to reimburse Sleep Solutions for services provided to Patient.

6) Patient acknowledges and understands that: a) a physician who is not part of Sleep Solutions will professionally interpret all sleep studies performed upon Patient, and b) Patient and/or Patient's third party payor will be billed separately for this service.

AGREED AND ACKNOWLEDGED

_____
Patient Signature

_____
Patient Name

_____
Date

Notice of Privacy Practices

Dear Patient:

This policy document describes how we may use your Protected Health Information and how you can get access to this information. Please review it carefully.

This Sleep Solutions Privacy Policy has been developed to ensure that we follow all federal and state privacy protection laws and regulations, in particular the Health Insurance Portability and Accountability Act of 1996. (HIPAA). Protection of patient privacy is of paramount importance to Sleep Solutions. Sleep Solutions protects the privacy of your **Protected Health Information**. Such information may not be disclosed to third parties unless authorized by one or more of the provisions set forth below.

This policy shall become effective as of March 1, 2007, and shall remain in effect, as amended, until it is formally terminated.

If a patient has any questions or concerns relating to this policy or its coverage, the patient should contact the Sleep Solutions Chief Executive Office (who also serves as the company's Chief Privacy Officer), Sleep Solutions, 1341 Ochsner Blvd., Covington, Louisiana 70433 by mail, by telephone at (985) 875-7557 or by fax (985) 875-0595.

Definitions

For the purposes of this policy, the following defined terms shall have the following definitions:

a) "**HHS**" shall mean the United States Department of Health and Human Services.

b) "**Health Information**" or "**Protected Health Information**" shall mean, certain individual, identifiable health information, as defined at 45 CFR 164.501.

Information Collected or Created By Sleep Solutions

In the ordinary course of its business operations, Sleep Solutions may receive certain personal information (all of which shall be considered **Protected Health Information**) such as:

- The patient's name, address, and telephone number(s);
- Information relating to the patient's treatment, diagnosis or other medical information concerning the patient;
- Patient's insurance information and coverage specifics.

In addition, other patient-specific information will be created by Sleep Solutions. All of the patient-specific types of information described above are stored and maintained in either paper form or digitally on Sleep Solutions computer systems. The totality of this maintained information constitutes the patient's medical record. The original medical record itself is the property of Sleep Solutions, but the information contained in the medical record (all of which constitutes **Protected Health Information**).

How Sleep Solutions May Use Or Disclose A Patient's Protected Health Information

Disclosures of **Protected Health Information** to third parties directly involved either in a patient's treatment and care or in a payment for a patient's treatment and care may be made as follows:

a) Treatment Purposes. Sleep Solutions collects information from the patient regarding the patient's past medical history, present medical problems and/or complaints as well as any diagnosis and/or medical treatment. By undergoing treatment by Sleep Solutions the patient agrees the this information may be shared with: a) various departments within our organization, b) the patient's referring physician, c) any other person or entity involved in the patient's treatment, or d) health insurance payor.

b) Payment Purposes. Sleep Solutions will collect certain demographic and payment/insurance information from or about a patient including, but not limited to, the patient's full name, address, social security number, date of birth, health insurance carrier, deductible, co-insurance and policy number. By undergoing treatment by Sleep Solutions the patient agrees that this information may be shared with: a) the patient's health insurance payor, b) the Medicare and Medicaid programs, or c) any other payor of healthcare claims.

c) Voice Mail Messages: By undergoing treatment by Sleep Solutions the patient agrees that Protected Health Information may be contained in messages left either with individuals or upon machines at patient's home or other number the patient provides to Sleep Solutions.

d) Protected Health Information may be shared with any person or organization as permitted by applicable law or regulation.

e) Protected Health Information may be shared with any person or organization as authorized by the patient.

Accounting of Disclosures

When requested in writing by a patient Sleep Solutions shall provide to a patient an accounting of disclosures of **Protected Health Information** made by Sleep Solutions.

Complaints

All complaints by patients relating to **Protected Health Information** shall be investigated in a timely fashion. Patient complaints about Sleep Solutions' handling of **Protected Health Information** shall be in writing and addressed to:

Chief Executive Officer
(Chief Privacy Officer)
Sleep Solutions
1341 Ochsner Blvd
Covington, Louisiana 70433

If a patient is not satisfied with the manner in which a complaint is handled, the patient may submit a formal complaint to

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F
Washington, DC 20201

Retaliation for Patient Complaints

No Sleep Solutions employee or representative may engage in any intimidating or retaliatory acts or actions against any patient who asserts a complaint or otherwise exercises his/her rights under HIPAA.

Withholding Protected Health Information

No patient-requested disclosure of **Protected Health Information** will be withheld as a condition for payment for services provided by Sleep Solutions.

Responsibility For Compliance

Responsibility for compliance with this Policy's provisions lies with the Sleep Solutions Chief Executive Officer (who also serves in the capacity of Chief Privacy Officer).

Business Associates

Disclosures of **Protected Health Information** may be made to additional party business associates (other than those described above) provided the other party has executed a Business Associate Agreement under which the party contractually agrees to treat and protect **Protected Health Information** in the same manner(s) set forth herein.

Preemption of State Law

If the provisions of HIPAA conflict with any state law or regulation relating to the protection of **Protected Health Information** and the provisions of state law or regulation are less stringent than those contained in HIPAA, the federal privacy rules contained in HIPAA shall prevail.

Patient Rights Statement

Dear Patient:

Welcome. Thank you for choosing Sleep Solutions as your sleep-related healthcare provider. Your sleep health and hygiene are important to us. Our goal is to provide the highest quality sleep-related services.

As a patient of Sleep Solutions, we want you to know that you have the following rights:

1) You have the right to be treated with respect, courtesy and dignity.

2) You have the right to receive understandable information regarding the sleep-related services your physician has ordered for you in order for you to make informed decisions about your care.

3) You have the right to refuse treatment or care.

4) You have the right to personal privacy in all aspects of your care.

5) You have the right to expect confidentiality of all records and communications about your care.

6) Upon request, you have the right to review and understand the disclosures of patient health information that are made by Sleep Solutions and agree in writing to each such disclosure in advance of the occurrence of the disclosure. You have the right to deny Sleep Solutions the right to make any such disclosure.

Finally, we must advise that due to the limited array of services Sleep Solutions provides, we cannot honor any Living Will Declaration that may have been executed by a patient.

The Sleep Solutions Corporate Office
1341 Ochsner Blvd.
Covington, Louisiana 70433
Phone: 985-875-7557 Fax: 985-875-0595

Patient Responsibilities Statement

Dear Patient:

Welcome. Thank you for choosing Sleep Solutions as your sleep-related healthcare provider. Your sleep health and hygiene are important to us. Our goal is to provide the highest quality sleep-related services.

As a patient of Sleep Solutions, we want you to know that you have the following responsibilities in connection with your care:

1. You have the responsibility to accurately provide complete:
    a) demographic information,
    b) payor information,
    c) clinical information, and
    d) feed back during and following testing or treatment.

2. You are expected to ask questions when you don't understand your care or the role you are expected to play in its delivery.

3. You are expected to comply with the treatment and care plan.

4. Sub-optimal testing and treatment outcomes can result from your failure to comply with testing or treatment-related instructions.

5. You are expected to follow Sleep Solutions' rules and instructions.

6. Sleep Solutions will verify your insurance benefits before testing or treatment is performed. You will be informed of your financial responsibility before testing or treatment is performed. You are expected to pay your out-of-pocket amount before the testing or treatment is performed. If you are unable to pay the required amount, Sleep Solutions offers payment plans. If you agree to a payment plan, Sleep Solutions will then perform the testing or treatment.

You are expected to immediately forward to Sleep Solutions any payment you receive from an insurance company relating to your care at Sleep Solutions that represents a payment that is actually due to Sleep Solutions.

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BRING THIS COMPLETED FORM WITH YOU ON THE NIGHT OF YOUR SLEEP STUDY

PATIENT AUTHORIZATION TO APPEAL INADEQUATE INSURANCE PAYMENT

Patient authorizes Sleep Solutions to appeal any and all claims related to goods and services provided by Sleep Solutions, directly to patient's insurance company.

Sleep Solutions reserves the right to appeal for any reason deemed necessary to receive reasonable reimbursement for services rendered not to exceed the charges billed.

Patient agrees to cooperate fully in the appeal process, as reasonably requested by Sleep Solutions (e.g. prompt response to insurance company requests for additional information).

AGREED AND ACKNOWLEDGED

_____
Patient Signature

_____
Patient Name (Print)

_____
Date

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Sleep Solutions Is Accredited By The Joint Commission

Notice Regarding Patient Safety Concern

Sleep Solutions is vitally interested in maintaining a safe environment for our patients. We want to know if an unsafe condition exists. If, during the course of your care and treatment, you encounter a situation that poses a safety risk, we ask that you point it out to the direct patient care provider responsible for your care. The Direct patient care provider will complete an Incident Report Form that will be carefully reviewed by the Sleep Solutions CEO and, ultimately, by the Sleep Solutions Performance Improvement Committee.

If, after reporting the condition, you feel that the situation has not been adequately addressed, you are encouraged to contact **The Joint Commission** at 1-**800-994-6610**. Alternatively, you can send an email message to **complaint@jointcommission.org.**

Thank you.

The Sleep Solutions Corporate Office
1341 Ochsner Blvd.
Covington, Louisiana 70433
Phone: 985-875-7557 Fax: 985-875-0595

Patient Complaint Form

Dear Patient:

We always strive to deliver the best possible care and service to our patients. We are always open to constructive criticism. If you feel that the care or service you received as a Sleep Solutions patient was not up to par, we ask that you complete this form. Please provide as much specific information as possible. Any information you provide will be kept confidential.

After you have completed this form, please sign and mail to the address below.

Name of Patient: _____

Date of Care: _____

Location of Care: _____

Please Describe The Problem You Experienced:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Would You Like To Hear Back From Us? ____ Yes ____ No

Your Signature: _____

Thank you for your feed-back.

03/08

The Sleep Solutions Corporate Office
1341 Ochsner Blvd.
Covington, Louisiana 70433
Phone: 985-875-7557 Fax: 985-875-0595

Patient Satisfaction Survey

Dear Patient:

We always strive to deliver the best possible care and service to our patients. Please help us to improve by completing this survey about your experience with us. After you have completed this form, please mail to the address below.

Name of Patient (Optional): _____

Date of Care: _____

Location of Care: _____

I. The Scheduling Encounter
a) Did the scheduler introduce himself/herself to you? _____ Yes, ____ No
b) Was the scheduler helpful and polite? ____ Yes, ____ No
c) Did the scheduler explain the care you were going to receive? ____ Yes, ____ No
d) Did the scheduler explain your financial responsibilities to you fully? ____ Yes, ____ No
e) Did the scheduler answer all of your questions to your satisfaction? ____ Yes, ____ No

II. The Clinical Encounter
a) Did the care giver introduce himself/herself to you? _____ Yes, ____ No
b) Was the care giver polite? ____ Yes, ____ No
c) Did the care giver go over paperwork with you? ____ Yes, ____ No
d) Did the care giver explain the care you were going to receive? ____ Yes, ____ No
e) Did the care giver put you at ease before you went to sleep? ____ Yes, ____ No
f) Was the care giver attendant to your needs during the night? ____ Yes, ____ No

III. The Physical Environment
a) Was your room clean? ____ Yes; ____ No
b) Was the bed comfortable? ____ Yes, ____ No
c) Was the room temperature comfortable? ____ Yes, ____ No

IV. Explanations
Please explain any "No" answer.
_____
_____
_____
_____

V. Would You Like To Hear Back From Us? ____ Yes ____ No

Thank you for your feed-back. 03/08

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