PT ID # : _____

WESTERN SLEEP MEDICINE, LLC

Mark Schultz, RPSGT
Dr. Gerald Amundsen

Central Scheduling: 416 Valley View Drive, Suite 400, Scottsbluff, Nebraska 69361 (307)-426-4012 or (308)-633-3000 (308)-633-3001 fax

Serving Kimball Health Services – 505 South Burg Street, Kimball, Nebraska 69145

Hello!

We are looking forward to meeting you and performing your sleep study! Enclosed you will find a questionnaire, sleep diary and general instructions. We need you to bring this questionnaire and sleep diary with you the night of your sleep study at our sleep lab located at Kimball Health Services in Kimball. Please complete the medications list and bed partner questionnaire if applicable.

On the day of your study please refrain from taking a nap and do try your best to limit your caffeine intake. Also, please shower and wash your hair before coming. We will be placing six small sensors on your scalp and this helps us get the best readings possible.

If you have any questions please call Central Scheduling Monday through Friday between the hours of 9:00 am to 4:00 pm. Our office telephone is (308)-633-3000. Pam or Mark will be happy to answer any questions you may have.

Thank you again for choosing Western Sleep Medicine in Kimball. We look forward to serving You!

Western Sleep Medicine is staffed by Registered Polysomnographers, Registered Nurses, and a Registered Respiratory Therapist.

Revised 6-01-10

PT ID # : _____

SLEEP STUDY INSTRUCTIONS

PATIENT NAME: _____

Your nighttime sleep study is scheduled for: _____

It is very important for you to read the following information and complete the questionnaires before coming to the Sleep Lab

.

THINGS TO REMEMBER

- Day of study, **do not** take a nap, try to keep busy.
- Day of study, please limit your caffeine intake, also **no** consumption of caffeine products after 12 noon (coffee, sodas and chocolate).
- Arrive at the Sleep Lab, **Kimball Health Services,** 505 South Burg Street, Kimball, NE at _____ p.m.
  Please park out front and Come on in*!*
- Please shower, wash your hair and refrain from using any hair care products. If you normally shave then please do so the day of your test.
- Please be aware that during your study you will not be allowed to have the following with you in your room; pagers, personal phones or watches as they interfere with the test results. If a phone or pager must be brought in with you, then the technician in charge of your testing will be more than happy to keep it in the observation room in case of emergencies.

PLEASE BRING WITH YOU

- **Toiletry items**: Combs/hair brush, toothbrush/toothpaste.
- **Clothes**: Loose fitting nightclothes and a change of clothes for the next day.
- **Medications**: Any medication that is prescribed by your doctor, or over the counter medications you are currently taking and a current list of your medications.

******No Medication will be Administered by our Staff******

- **Diabetic Supplies:** Please bring your glucometer and supplies.
- **Reading Material**: Something to help relax in your room before your test.
- **Questionnaire:** Please bring the completed questionnaire previously sent to you.

If you become sick or cannot make your scheduled appointment, please
call Pam @ Central Scheduling in Scottsbluff (308) 633-3000
Before 1:00 p.m

Revised 6-01-10

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PATIENT SLEEP STUDY INFORMATION

What is a Polysomnogram?

A Polysomnogram is a procedure that reads and registers body functions during sleep. Some of these measurements include:

- **Brain waves** [Electrodes placed on patient's scalp]
- **Heart beats**
- **Eye Movements** [Electrodes placed by the patient's eyes]
- **Leg movements** [Electrodes placed on the patient's legs]
- **Airflow Breathing** [Sensor placed under the patient's nose]
- **Chest/Abdominal Breathing** [Sensors placed on the patient's chest and abdomen]
- **Blood Oxygen Levels** [Sensor attached to the patient's finger]

Why Record This Information?

During sleep, the body functions differently than while awake. Recording these readings will help the doctors better diagnose and treat your sleep problem.

How Can I Sleep With All Of These Things On Me?

Surprisingly, most people sleep reasonably well. The sensors are applied so that you can turn and move during sleep. Our staff will try to make your environment as comfortable as possible.

Will The Sensor Devices Hurt?

No. Although sometimes in rubbing the skin or putting on the electrodes there will be mild and temporary discomfort and skin irritations.

Will I Be Given A Drug To Help Me Sleep?

No, unless these have been prescribed by your doctor. ***PLEASE, DO NOT STOP ANY OF YOUR MEDICATIONS WITHOUT FIRST CONSULTING YOUR PERSONAL PHYSICIAN!***

What Should I Bring?

Your own pillow, bed clothes [Preferably two piece pajamas or gym shorts and T-shirt], and a book of something to work on while waiting. **Bring Your Prescribed Medications!**

What Happens To The Polysomnogram?

Sleep studies are reviewed the following day by Mark Schultz, RPSGT and forwarded to Dr. Norman Imes, Clinical Professor of Medicine, OU Health Sciences Center and A Diplomate of the American Board of Internal Medicine, Sleep Medicine. Dr. Imes is licensed and recognized nationally as an expert in the field of sleep medicine. Generally, results will be returned to your physician within 3 working days of the date of your study. Your primary care physician will contact you for a follow up visit to review your results.

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INSTRUCTIONS FOR COMPLETING QUESTIONNAIRES

While an extensive sleep history will be taken by the Sleep Technician the night of your study, answering these questionnaires will aid in the diagnostic process. Enclosed are the following questionnaires:

1. MEDICATIONS LIST
   - It is IMPORTANT that you provide the Sleep Technician with a complete list of your current medications with the dosage and daily intake clearly stated.
2. SLEEP LOG/SLEEP HISTORY
   - Please begin this as soon as you receive the questionnaire packet.
3. QUESTIONS ABOUT YOUR SLEEP AND WAKE BEHAVIOR
   - please be as thorough as possible
4. BED PARTNER QUESTIONNAIRES
   - If you have a bed partner who has recently observed your sleep please have them complete this questionnaire.
5. EPWORTH SLEEPINESS SCALE
   - This is a standard medical assessment that is scored by the registered sleep technologist and aids in your diagnosis.

PLEASE BRING THESE COMPLETED QUESTIONNAIRES WITH YOU TO THE SLEEP LAB FOR EVALUATION _____THE NIGHT OF YOUR STUDY_____

PT ID # : _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Address: _____Phone: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____

Other Physician to Receive: _____

Pt Weight: _____ Pt. Height: _____ BMI _____ Neck Size: _____ Epworth Scale_____

Date of Study: _____ Sleep Technologist: _____

TEST OBSERVATIONS

Baseline SaO2_____% w/ O2 _____ Lowest SaO2 _____ % w/ O2 _____

Abnormal Events Observed

Obstructive: ___ Central: ___ Mixed: ___ Hypopneas: ___ Snore Arousals: ___ Periodic Limb ___

PROCEDURE

Lights Out: _____ AHI Index Needed: _____ Lights On: _____

(Biologic)Start Segment Epoch PSG: _____ End Segment Epoch PSG: _____

Diagnostic PSG: _____ Split Night Polysomnogram ____ CPAP/BIPAP Titration Study _____

A. ___ Events Witnessed, but did not meet Split Night Protocol
B. ___ Protocol met, but too late in the study to initiate trial of CPAP titration.
C. ___ Events Witnessed, but Medicare Guidelines

Beginning B/P: _____ Ending B/P: _____

Supplemental Oxygen Administered Epoch: _____LPM: _____

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pt. Dismissed at: _____

PT ID # : _____

(Biologic) Start Segment Epoch Titration: _____ End Segment Epoch Titration: _____

WESTERN SLEEP MEDICINE THERAPY SHEET

EPOCH	PRESSURE	HUMIDITY	LEAK	MASK	NOTES:
SUPPLEMTENTAL OXYGEN					
EPOCH	**AMOUNT**	**ROUTE**	**SaO2**		**NOTES:**

FINAL NOTES

CPAP- Final Pressure _____cm H_20 **Bi-PAP**- Final Pressure IPAP_____ EPAP_____

Auto SV- EPAP min = _____cm H_20 EPAP max = _____ cm H_20 Max Pressure = _____ cm H_20

PS min = _____cm H_20 PS max = _____ cm H_20 Breath Rate= Auto or _____ BPM

Insp Time = _____ seconds (w fixed rate only) Rise time/Bi-flex to Pt Comfort _____

Mask Company-_____ **Mask Style**-_____ **Mask Size**_____

COMMENTS:_____

_____

_____

_____

_____

_____

_____

Dismissal Time: _____

PT ID # : _____

SLEEP QUESTIONNAIRE

PATIENTS NAME: _____ SOCIAL SECURITY NUMBER:_____

DOB: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

WHAT PROBLEMS DO YOU HAVE WITH SLEEP?

PLEASE CHECK ALL THAT APPLY

Loud snoring	Tired/sleepy during the day	Sleep talking
Toss and turn in bed	Difficulty falling asleep	Sleep walking
Frequent awakenings	Legs movement at night	Act out dreams
Shallow breathing at night	Legs uncomfortable at night	Teeth grinding
Stop breathing during sleep	Muscle cramps at night	Bed-wetting

CIRCLE LEVEL OF SNORING: 0 1 2 3 4 5 6 7 8 9 10

Circle position(s) of sleep snoring is heard: Left side Right side Back Stomach

How many years has snoring occurred? _____ Worsened over how long? _____
How many nights a week, on average, are you disturbed by poor sleep? _____

Has snoring caused you or bed partner to move to another room? YES / NO
Has your own snoring awakened you from sleep? YES / NO
Have you had any facial injury or a broken nose? YES / NO
Have you undergone any nose or throat surgery, including tonsillectomy? YES / NO
Do you awaken with a headache? YES / NO
Has anyone noticed periods where you stop breathing at night? YES / NO

SLEEP HABITS

What time do you usually get into bed at night? _____
How long does it take you to fall asleep? _____
How many times do you awaken at night? _____ Why?_____
What time do you get up in the morning? _____
Do you feel refreshed or still tired? Comments: _____
Rate your level of energy during the day. (poor) 0 1 2 3 4 5 6 7 8 9 10 (excellent)
Do you take naps? YES / NO
Do you feel refreshed after a nap? YES / NO
Do you ever doze or nod off if you sit for awhile? YES / NO
Are you a shift worker? YES/NO If so, what shift? _____

LEG MOVEMENT

I have an aching or crawling sensation in my legs in the evening. YES / NO
I cannot keep my legs still in the evening YES / NO
I have an unpleasant sensation in my legs that improves with activity and gets worse with rest or inactivity. YES / NO

OTHER QUESTIONS

How much caffeine do you consume during each day? _____ Coffee: _____ Cola/tea/etc. _____
Do you drink alcohol before bedtime? (kind and number of drinks) _____
Sudden weakness with strong emotion (anger or laughter) YES / NO
Indigestion / heartburn during sleep? YES / NO
Paralysis on waking or falling asleep? YES / NO
Hallucination on waking or falling asleep? YES / No

PT ID # : _____

GENERAL HEALTH QUESTIONS

Previous and Current Medical Problems and Illnesses

YEAR	ILLNESS OR MEDICAL PROBLEM	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Surgeries

YEAR	ILLNESS OR MEDICAL PROBLEM	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: to medications, plants, foods, dust molds, etc.

Medication/allergen	Reaction	Medication/allergen	Reaction
1) _____	_____	3) _____	_____
2) _____	_____	4)_____	_____

Medications

Please list all medications, vitamins, herbal supplements you are currently taking

MEDICATION: DOSAGE: # PER DAY_ REASON FOR TAKING:_____

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____

Have you ever used "recreational" drugs? YES / NO

IF YES PLEASE CIRCLE: LSD COCAINE AMPHETAMINES MARIJAUNA / HASHISH INHALENTS / AEROSOLS *OTHER*

Personal Habits

Tobacco Do you currently smoke or chew? Yes / No Amount per day _____

Travel Miles traveled daily to work, during, work, or for recreation._____

Diet: Special diet or eating habits: _____

Do You Exercise? Walk_____ Aerobic_____ Other _____ No_____

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BED PARTNER QUESTIONNAIRE

NAME OF PATIENT:_____ DATE:_____

NAME OF PERSON FILLING OUT FORM:_____

I HAVE OBSERVED THIS PERSON SLEEP:

ONCE OR TWICE FREQUENTLY EVERY NIGHT

PLEASE CHECK ANY OF THE FOLLOWING BEHAVIORS OBSERVED WHILE THIS PERSON WAS SLEEPING

Light Snoring	Loud snoring	Occasional loud snorts	Choking
Grinding Teeth	Leg Movement	Pauses in Breathing	Crying Out
Awakening in Pain	Becoming ridged	Sitting up in bed not awake	

Other:_____

Please describe any additional comments you have about the sleep disorders above. Might want to include activity, the time during the night in which it happens, frequency during the night, and whether it occurs every night.

Has this person ever fallen asleep during normal daytime activities or in potentially dangerous situations?

Yes No

If yes, please explain:

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Scottsbluff
FAX 308.633.3001

WESTERN SLEEP MEDICINE

416 Valley View Drive, Suite 400, Scottsbluff, Nebraska 69361 308.633.3000 308.633.3001 fax

Scottsbluff
FAX 308.633.3001

PHYSICIAN ORDER FORM - PATIENT REGISTRATION FORM

Patient Name: _____ Social Security #:_____
DOB: _____

Patient Address: _____
Phone: _____(H) _____(W)

INSURANCE INFORMATION:

Primary Insurance: _____ Policy #: _____
Subscriber's Name: _____

PHYSICIAN INFORMATION:

Referring Physician (name): _____ Phone #: _____Pager #_____
For Notification in Case of Emergency
Referring Physician (signature): _____

STUDY REQUEST

☐ Standard Sleep Study (Split Night): All night 16 channel diagnostic PSG w/CPAP therapy if severe apnea present.
☐ Titration Study if Recommended by Interpreting Physician: Provide a Full Night PAP titration.
☐ Assist CPAP/BiPAP Set-Up: Coordinate CPAP or BiPAP treatment & equipment if indicated by Sleep Study.
DME Provider _____.
☐ Multiple Sleep Latency Test: Follow nighttime test with daytime nap testing for Narcolepsy, or other diagnosis.
☐ Maintenance of Wakefulness Test: Follow nighttime testing with daytime naps to determine vigilance.

MEDICAL SYMPTOMS: (Pre-certification, please check *ALL* that apply)

☐ Witnessed breath holds while sleeping
☐ Inappropriate sleep episodes or attacks
☐ Falling asleep at inappropriate times
☐ Disturbed nocturnal sleep
☐ Waking gasping for breath
☐ Excessive Daytime sleepiness
☐ Continuous disabling drowsiness
☐ Sleep terrors
☐ Amnesiac episodes
☐ Other Medical Symptoms

OTHER MEDICAL SYMPTOMS: (Check *ALL* that apply)

☐ Snoring ☐ Over weight ☐ Insomnia ☐ Nightmares ☐ Bruxism
☐ Leg cramps ☐ Muscle/joint aches ☐ Seizures ☐ CHF ☐ Depression
☐ Hypertension ☐ Pulmonary Disease ☐ Sleep walking ☐ Diabetes ☐ Anxiety
☐ Arrhythmia (specify): _____

SPECIAL NEEDS FOR CONSIDERATION DURING STUDY: (Check all that apply)

□ Oxygen: _____ L/min: _____ 24 hr. _____ Nocturnal
□ Walker, wheelchair, assistance walking □ Morbidly Obese, Recliner Possibly Needed
□ Psychiatric/Mental Impairment problems that may affect study (specify): _____
□ Medications: Oral and injectable medications can only be administered by patient!
■ Instruct the Pt to bring Personal Medications from Home to be taken as Prescribed.

FAX THIS FORM TO WESTERN SLEEP MEDICINE
Scottsbluff (308) 633-3001
Thank You! *Revised 06-01-10*

PT ID # : _____

EPWORTH SLEEPINESS SCALE

NAME: _____

DATE: _____ AGE: _____

GENDER: (circle one) MALE FEMALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 off
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 (e.g., 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 permitted	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch with no alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: _____ AVG. AMOUNT(HOURS) OF SLEEP PER NIGHT _____

PT ID # : _____

SLEEP DIARY

NAME _____

START DATE _____ COMPLETION DATE _____

Please darken the times with pen that you are asleep during the daytime and/or nighttime

Date	Day	6am	7am	8am	9am	10am	11am	noon	1pm	2pm	3pm	4pm	5pm
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

Date	Day	6pm	7pm	8pm	9pm	10pm	11pm	mid-night	1am	2am	3am	4am	5am
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												

If sleeping medications were taken, please make note of the medication, and star the date/time that these medications were taken. _____

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WESTERN SLEEP MEDICINE, LLC

Mark Schultz, RPSGT
Dr. Gerald Amundsen

POST SLEEP STUDY QUESTIONNAIRE

Please mark your answers and fill in the blanks where applicable.

1. How long did it take you to fall asleep last night?
   ❑ Immediately ❑ Few minutes ❑ Hours ❑ Did not fall asleep
2. How does this compare to the time it usually takes you to fall asleep?
   ❑ Same ❑ Shorter time ❑ Longer time
3. How many hours of sleep do you think you got? _____
4. How does this compare to the amount of sleep you normally get?
   ❑ Same ❑ Less than normal ❑ More than normal
5. Did you dream? ❑ Yes ❑ No
6. How much dreaming do you remember?
   ❑ None ❑ Less than usual ❑ More than usual
7. Did you wake up?
   ❑ More than usual ❑ Same ❑ Less than usual
8. How many times do you remember waking up before the end of the study? _____
   Why did you wake up? _____
9. How did you feel immediately after you woke up?
   ❑ Sleepy ❑ Somewhat alert ❑ Wide awake
10. How did you feel 10 to 15 minutes after waking up?
    ❑ Sleepy ❑ Somewhat alert ❑ Wide awake
11. In general, how did you sleep?
    ❑ Poorly ❑ Same as usual ❑ Better

Please answer questions 12-16 if you used CPAP/BiPAP.

12. How did you tolerate the mask and pressure?
    ❑ Poorly ❑ Well ❑ Very well
13. Do you feel rested? ❑ Yes ❑ No
14. Do you think you snored less when using CPAP? ❑ Yes ❑ No
15. How did you sleep with CPAP?
    ❑ Better ❑ Same as usual ❑ Worse
16. Please explain any problems you had with the CPAP therapy: _____
    _____
    _____

Thank you for completing this questionnaire!

Please remember to make an appointment with your physician to discuss the results of your sleep study

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

Revised 06-01-10

PT ID # : _____

PATIENT INFORMATION

PATIENTS NAME: _____
First Middle Last

ADDRESS:_____

CITY: _____ STATE: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: _____-_____-_____

AGE: _____ HEIGHT: _____ WEIGHT: _____ SEX: FEMALE MALE

MARITAL STATUS (Please Circle One) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: *(Please Circle One)* SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN:_____ REFERRED BY: _____

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____

EMERGENCY CONTACT: _____ Ph. #:_____ WORK PHONE: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESONSIBLE PARTY NAME: _____
If Same as Above Please Write **Same** First Middle Last

ADDRESS: _____

CITY: _____ STATE: _____ POSTAL CODE: _____ SEX: FEMALE MALE

DATE OF BIRTH: _____/ _____/ _____ SOCIAL SECURITY NUMBER: _____-_____-_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

RESPONSIBLE PARTY'S EMPLOYER: _____ WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

GROUP NAME: _____ GROUP NUMBER:_____ CONTRACT (ID) NUMER: _____

SUBSCRIBERS NAME: _____ SUBSCRIBER DATE OF BIRTH _____/ _____/ _____

PATIENT RELATIONSHIP TO SUBSCRIBER: *Please Circle One* SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE COMPANY/ MEDICARE SUPPLEMENT: _____

ADDRESS: _____ PHONE: _____

GROUP NAME: _____ GROUP NUMBER:_____ CONTRACT (ID) NUMER: _____

SUBSCRIBERS NAME: _____ SUBSCRIBER DATE OF BIRTH _____/ _____/ _____

PATIENT RELATIONSHIP TO SUBSCRIBER: *Please Circle One* SELF SPOUSE CHILD OTHER

PT ID # : _____

WESTERN SLEEP MEDICINE, LLC

Mark Schultz, RPSGT
Dr. Gerald Amundsen

SLEEP STUDY CONSENT FORM

Patient Name: _____ **DOB**: _____

I authorize a Diagnostic PSG, Split Night or Titration sleep study to be performed under the medical direction of Norman K Imes, M.D. Dr. Imes has board certification by the American Board of Medical Specialties in Internal Medicine, Pulmonary Disease, and Sleep Medicine. He is licensed to practice medicine in Oklahoma, Nebraska, Wyoming, and South Dakota.

The nature and purpose of this as well as the risks involved and possible complications have been fully explained to me. No individual with Western Sleep Medicine or my physician's office has given me a guarantee or assurance as to the results that may be attained. I have been informed prior to tonight that the technician performing the study may be of the opposite sex and have agreed to continue with the test.

I understand a video monitoring and recording will be performed as part of the diagnostic test. I hereby give permission to release my medical information that may be deemed necessary as part of this procedure. I also understand and consent to the results of this procedure being released to other physicians as deemed necessary in my continued care.

I have been verbally informed of my responsibilities and all of the procedures governing patient conduct and responsibilities, and that a written copy of this information will be provided upon my request. The undersigned acknowledges receipt of this information. I understand when the patient is not a consenting adult or is incapacitated the signing must be witnessed by a third person.

I consent to any examinations and diagnostic testing, specialized therapies, or other medical interventions such as photography, and video camera monitoring of patients. I also recognize that all physicians that consult and furnish services privileged by the lab to provide such services. The lab is not liable if the patient does not follow the instructions of his or her attending and or physician during or after the testing period. Charges for services rendered by physicians are not included in the labs bill.

I was advised not to bring valuables during my stay at the lab. The lab shall not be liable for the loss or damage to any monies, jewelry, glasses, dentures, clothes and other items of personnel value.

The family is responsible for all transportation to and from the lab.

I understand the billing of this procedure will be managed by Western Sleep Medicine, L.L.C. Any benefits paid on my behalf will be paid to Western Sleep Medicine, L.L.C. I understand that sleep services must be analyzed and interpreted by a qualified sleep specialist and a separate bill for the professional interpretation of this sleep test will be sent from Pulmonology Sleep Services of Oklahoma City, Oklahoma. The appropriate diagnoses and recommendations will be sent to my referring physician.

_____

Patient's Name Patient's Signature Date

_____

Witness' Name Witness' Signature Date

**If the patient is under 17 years old or incapacitated, please have a third person witness the signing of this consent form.*

_____

Witness' Name Witness' Signature Date

416 Valley View Drive Suite 400, Scottsbluff, Nebraska 69361 308.633.3000 308.633.3001 fax
mschultz@westernsleep.net www.westernsleepmedicine.com

Revised 06-01-10

PT ID # : _____

WESTERN SLEEP MEDICINE, LLC

Mark Schultz, RPSGT
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPTIONS

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with Western Sleep Medicine's Notice of Privacy Practices that provides a more complete description of my health information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

In addition to disclosure for treatment, payment and healthcare operations, the following individual(s) is/are allowed access to my personal health information *(please indicate relationship to you):*

_____

I fully understand and **ACCEPT** the terms of this consent.

_____ _____

Patient Signature **Date**

PT ID # : _____

WESTERN SLEEP MEDICINE, LLC

Mark Schultz, RPSGT
Dr. Gerald Amundsen

416 Valley View Drive, Suite 400, Scottsbluff, Nebraska 69361 308.633.3000 308.633.3001 fax
4100 Laramie Street, Cheyenne, Wyoming 82001 307.426.4012 308.633.3001 fax

Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at Western Sleep Medicine, to communicate openly with us. We want you to participate in your treatment, make choices and promote your own safety by being well informed of the complexity of sleep related breathing disorders and remaining actively involved in your care. We want you to think of yourself as a partner in your care, and we want you to know your rights as well as your responsibilities during your stay. We invite you and your family to join us as active members of your care team.

Your Rights

You have the right to receive considerate, respectful and compassionate care regardless of your age, gender, race, national origin, religion, sexual orientation or disabilities.

You have the right to receive care in a safe environment free from all forms of abuse, neglect or harassment.

You have the right to be called by your proper name and to be told the names of the doctors, nurses and other health care team members involved in your care.

You have the right to be told by your referring doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and expected outcome of treatment, including unanticipated outcomes. You have the right to give written informed consent before any non-emergency procedure begins.

You have the right to be free from restraints and seclusion in any form that is not medically required.

You can expect full consideration of your privacy and confidentiality in care discussions, diagnostic testing and treatments.

You have the right to access protective and advocacy services in cases of abuse or neglect.

You, and family members or friends with your permission, have the right to participate in decisions about your care, treatment and services provided, including the right to refuse treatment to the extent permitted by law. However, if you terminate your sleep study prematurely and leave the sleep lab against medical advice the staff of Western Sleep Medicine, your referring physician and our interpreting physician will not be responsible for any medical consequences that may occur.

You have the right to be involved in your discharge plan. Before your discharge, you can expect to receive information about follow-up care that you may need.

You have the right to receive detailed information about your sleep lab and interpreting physician charges.

You can expect that all communications and records about your care are confidential, unless disclosure is allowed by law. You have the right to see or get a copy of your medical records from your referring physician and have the information explained, if needed. Upon review, you may add information to your medical record by contacting our central office in Scottsbluff. Upon request, you have the right to receive a list of who your personal health information was disclosed to.

If you or a family member needs to discuss an ethical issue related to your care, Mark Schultz, RPSGT or Dr. Gerald Amundsen are available for consultation. Please contact our office and ask to speak to one of them.

You have the right to voice your concerns about the care you receive. If you have a problem or complaint you may talk with Mark Schultz, RPSGT or Dr Gerald Amundsen at any time.

PT ID # : _____

PATIENT COPY

If your complaint is not resolved to your satisfaction
You have the right to request a review by the following organizations:

Accreditation Commission for Health Care
4700 Falls of Neuse Road, Raleigh North Carolina, 27609 919-785-1214
Contact the ACHC and request the Complaints Department, or go to www.achc.org

Nebraska Department of Health
P.O. Box 95026, Lincoln, Nebraska 68509-5026 402-471-3121

Your Responsibilities

You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.

You should provide Western Sleep Medicine with a copy of your advance directive if you have one.

You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.

You are expected to ask questions when you do not understand information or instructions. If you believe you can't follow through with your treatment plan, you are responsible for telling your care provider. You are responsible for outcomes if you do not follow the recommended care, treatment and services.

Please leave valuables at home and only bring necessary items for your stay at our sleep lab.

You are expected to treat all staff of Western Sleep Medicine and other patients and visitors with courtesy and respect; abide by all rules and safety regulations; and be mindful of noise levels and privacy.

You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.

You are expected to keep your appointment, be on time for your appointment, and to call the central office of Western Sleep Medicine at 308-633-3000 or 307-426-4012 if you cannot keep your appointment. Due to our standard of care which allows only 2 patients per sleep technologist, availability for testing is limited and often at a premium. You **must** contact our office NO LATER THAN 24 HOURS prior to your scheduled appointment; otherwise you will be assessed a $100 Cancellation fee.

I understand that prematurely terminating my sleep study against medical advice does not reduce or eliminate my financial responsibility for compensating the hospital and/or Western Sleep Medicine for expenses incurred if my insurance provider refuses the claim. If I choose to prematurely terminate my sleep study I release the staff and owners of Western Sleep Medicine, LLC, the medical director, and/or the hospital I am being treated in from any and all liability as a result of my decisions and or actions.

I have been informed of my Rights and Responsibilities as a Patient of Western Sleep Medicine.

_____ _____
Patient Guardian (if applicable)

_____Date

Revised 06-01-10

PT ID # : _____

CHART COPY

If your complaint is not resolved to your satisfaction
You have the right to request a review by the following organizations:

Accreditation Commission for Health Care
4700 Falls of Neuse Road, Raleigh North Carolina, 27609 919-785-1214
Contact the ACHC and request the Complaints Department, or go to www.achc.org

Nebraska Department of Health
P.O. Box 95026, Lincoln, Nebraska 68509-5026 402-471-3121

Your Responsibilities

You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer, when it is required.

You should provide Western Sleep Medicine with a copy of your advance directive if you have one.

You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.

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I have been informed of my Rights and Responsibilities as a Patient of Western Sleep Medicine.

_____ _____
Patient Guardian (if applicable)

_____Date

Revised 06-01-10

PT ID # : _____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physicians, our office staff and others outside of your office that are involved in your care and treatment for purpose of providing health care services to you , to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordinator or management of you health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides to you. For example, your protected health information may be provided to physicians to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities for your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school student that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physicians are ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physicians or the physician's practice has taken an action in reliance on the use or disclosure indication in the authorization. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 308-633-3000.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physicians are not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have to right to use another Healthcare Professional.

Your have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request.
You have the right to have your physician amend your protected health information. If we deny your requests for
amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints You may complain to us or to the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

PT ID # : _____

WESTERN SLEEP MEDICINE, LLC

416 Valley View Dr, Suite 400 Scottsbluff, Nebraska 69361 308.633.3000 308.633.3001 fax
4100 Laramie Street, Cheyenne, Wyoming 82001 307.426.4012 308.633.3001 fax

WHAT TO EXPECT NOW THAT YOUR SLEEP STUDY HAS BEEN COMPLETED

- Readings taken during your study are forwarded immediately to one of our RPSGTs. (Registered Polysomnographic Technologist) The RPSGT reads the study and assesses a "score".
- The study is forwarded to our Medical Director, Dr. Norman K. Imes, who reviews the data and scoring, and then writes a report based upon your score.
- Dr. Imes then sends back the finalized report and a copy is faxed to your doctor's office. We then follow up with a phone call to the doctor's office to make sure the fax was received. This process takes approximately 3 **working** days.
- Your doctor's office should contact you to discuss what the appropriate next step(s) are. If you would like a copy of the report for your records, you may request one from your doctor's office.
- Your doctor may ask that you complete a second "titration" study. Sometimes this is necessary based upon the results of the first study. This would mean that you would return to the sleep lab for a full night's sleep with CPAP. Our office will contact you to schedule this study once an order is received from your doctor.
- If a CPAP machine and/or oxygen are required, our accredited durable medical equipment company (Western CPAP Supply) can assist you. Our CPAP service includes the initial set up and review of operating procedures; and follow up with several "smart" card downloads to monitor your progress. The report generated by the download will be reviewed with you and a copy forwarded to your doctor, so they too are aware of your progress. We will also work to ensure the mask is fitting properly, and your leak is minimized. We also carry replacement masks and tubing for your convenience. If you would like our assistance with your CPAP machine and follow up please let your doctor know so they may forward the order to us.

THANK YOU FOR ALLOWING US TO SERVE YOU!

Revised 06-01-10