# Preparation and Guidelines for Nighttime Sleep Study

- Arrival time at our facility is at 8:30 P.M. and departure is between 5:00-6:00 A.M., unless otherwise instructed. THE FACILITY IS NOT UNLOCKED UNTIL 8:30 P.M.
- Bring your insurance cards and a photo id with completed paperwork on arrival.
- Bring footwear/slippers and clean pajamas or shorts and a shirt to sleep in during your study.
- Bring all your medications that you will need during your stay at the sleep center in their original bottle. PSDC does not administer any medications, including over the counter. Sleep medications may not be taken after 10 pm.
- Any medications that you bring **must** be listed on your questionnaire. You will be provided a lock box for secure storage of medications. While under our care the technologists will document all medications and their time taken. Any medications left at PSDC will be properly disposed of.
- PSDC does not provide storage for medications that require refrigeration. Patients must provide their own means of temperature controlled storage (i.e. cooler, ice chest etc.).
- Please shower, wash and dry your hair prior to arrival. Please do not use any other products in your hair after it is dried.
- In order for us to get an accurate test we ask that you please have clean, dry hair, do not wear any make-up, nail polish/false nails, hair extensions/weaves, or lotion the night of your study.
- **If you need any special assistance please let us know prior to your appointment so we may better assist you.**
- We ask that you leave all valuables at home. PSDC is not responsible for any personal items.
- There are not to be any firearms or weapons of any kind at any time on the grounds of PSDC.
- No animals of any kind are allowed on the property unless medically necessary.
- Due to safety reasons we ask that you shower at home the morning after your study.
- PSDC **does not** honor "Do not resuscitate" Advance Directives. Our policy is to call 911 in the event of a medical emergency. If you have any questions, comments or concerns regarding this policy please let our office know.

Signature: _____ Date: _____

**If for any reason you have to reschedule, we require 48 hours' notice. You will be charged $300.00 if you fail to give the required 48 hours' notice or fail to show up for your appointment.**

# General Information

**Patient Name**:

**First: _____M:_____ Last: _____Age**: _____ **Date of Birth**: _____/_____/_____

**SSN**: _____-_____-_____ **Sex**: Male/ Female **Marital Status**: Single Married Divorced Widow(er)

**Street Address**: _____**City**: _____ **State**: _____ **Zip code**: _____

**Home Phone**: _____ **Work Phone**: _____ **Cell Phone**:_____

**Responsible Party**: _____ **Relationship**: _____

**Emergency Contact**: _____ **Relationship**: _____ **Phone**: _____

# Insurance Information

Primary Insurance Company:

_____

Contract # (long number on card)

_____

Group # (short number on card)

_____

Insured name as it reads on the card:

_____

Secondary Insurance Company:

_____

Contract # (long number on card)

_____

Group # (short number on card)

_____

Insured name as it reads on the card:

_____

## INFORMATION RELEASE/AUTHORIZATION TO TREAT

I authorize payment of medical benefits to Pensacola Sleep Disorders Center for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/ or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

_____ _____/_____/_____

Patient, Parent or Guardian Signature (if under 18) Date

PENSACOLA SLEEP DISORDERS CENTER

## SLEEP HISTORY

What is the sleep problem you were referred for and for how long have you had this problem? :

_____

Have you ever been diagnosed with a sleep disorder in the past? **Yes / No** If so, what type of sleep disorder? _____

Are you experiencing any of the following symptoms?

| | | |
|---|---|---|
| __snoring | __ wake up with dry mouth | __wake lump in throat |
| __wake up coughing/choking | __ wake up short of breath | __wake up with headache |
| __feel very weak during day | __ daytime muscle aches | __heartburn at night |
| __sleep restlessly | __sleepwalk | __talk in sleep |
| __issues waking in the A.M. | __feel sleepy all day | __feel tired during the day |
| __feel paralyzed in bed | __wet the bed | __ have night sweats |
| __difficulty shutting mind off | __collapse when emotional | __leg cramps |
| __jerk during the night | __unable to keep legs still at bedtime | __act out your dreams |
| __move arms during sleep | __legs uncomfortable at bedtime | |
| __vivid dreams | __start dreaming when falling asleep | |

__nightmares or night terrors, if yes, do you remember them? Yes or No

What do you believe the cause of your sleep problem is?_____

## HEALTH HISTORY

Do you have or have you had the following:

| | | | | | |
|---|---|---|---|---|---|
| ____ | HIGH BLOOD PRESSURE | ____ | STROKE | ____ | HEART ATTACK |
| ____ | CHRONIC BACK PAIN | ____ | IRREGULAR HEART BEAT | ____ | ENLARGED PROSTATE |
| ____ | CONGESTIVE HEART FAILURE | ____ | GLAUCOMA | ____ | ANGINA OR CHEST PAINS |
| ____ | ALLERGIES/HAY FEVER | ____ | MITRAL VALVE PROLAPSE | ____ | DEVIATED NASAL SEPTUM |
| ____ | COPD or EMPHYSEMA | ____ | GOUT | ____ | ASTHMA |
| ____ | IRRITABLE BOWEL SYNDROME | ____ | DIABETES | ____ | ACID REFLUX |
| ____ | ARTHRITIS | ____ | MIGRAINE HEADACHES | ____ | ANXIETY |
| ____ | FIBROMYALGIA | ____ | DEPRESSION | ____ | CHRONIC FATIGUE SYNDROME |
| ____ | SEIZURE or EPILEPSY | ____ | TMJ SYNDROME | | |

Does anyone in your immediate family have any of the above problems? **Yes / No** If yes, who and what disorder?

_____

Have you been diagnosed with cancer? **Yes or No** Type? : _____Current status? _____

Please list any other significant medical conditions:_____

Please list all surgeries you have had:

_____

_____

## MEDICATION

Please list all of the medication you are currently taking

| Medication | Dosage | Medication | Dosage | Medication | Dosage |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

PENSACOLA SLEEP DISORDERS CENTER

# Sleep Hygiene

Describe your routine on weekdays: _____

Weekends: _____

Do you work shifts: Yes or No If yes to shift work, what shifts do you work? _____

**WEEKDAY SCHEDULE**

How many hours of sleep do you think you are getting a night? _____ What time do you actually get into bed? _____

Do you doze off before getting into bed? **Yes or No**

How long does it take to fall asleep once in bed? _____ Do you feel this is long, short, or normal? _____

How many times do you wake up during the night? _____ Do you feel this is normal? Yes or No

Why do you wake up during the night? _____Do you have difficulty going back to sleep? _____

What time do you wake up in the morning? _____ What time do you get out of bed? _____

**DOES YOUR SLEEP SCHEDULE CHANGE ON THE WEEKENDS? <u>If yes</u>, please answer the following questions. <u>IF NO</u>, CROSS THROUGH THE NEXT SET OF QUESTIONS.**

How many hours of sleep do you think you are getting a night? _____ What time do you actually get into bed? _____

Do you doze off before getting into bed? **Yes or No**

How long does it take to fall asleep once in bed? _____ Do you feel this is long, short, or normal? _____

How many times do you wake up during the night? _____ Do you feel this is normal? Yes or No

Why do you wake up during the night? _____Do you have difficulty going back to sleep? _____

What time do you wake up in the morning? _____ What time do you get out of bed? _____

**NAPS:**

Do you nap or doze off during the day? **Yes or No**

Do you take naps? _____ If yes, how many days per week and how long are the naps? _____

What time of the day do you feel sleepy most? _____ Do you feel alert after these naps? **Yes or No**

**Per Day Answers:**

| | | |
|---|---|---|
| Do you drink Reg/Decaf coffee? | **Yes or No** | if yes, how many: _____ |
| Reg/Decaf Tea? | **Yes or No** | if yes, how many: _____ |
| Do you drink REG or NO caffeine soft drinks? | **Yes or No** | if yes, how many: _____ |
| Do you eat chocolate? | **Yes or No** | if yes, how much: _____ |
| Do you smoke/ chew/ dip tobacco? | **Yes or No** | if yes, how much: _____ |
| Do you drink alcohol? | **Yes or No** | if yes, how much: _____ |
| Do you exercise regularly? | **Yes or No** | if yes how often: _____ |

If not, Why? _____

**<u>Sleep Environment</u>**

Is your bedroom quiet? **Yes or No**

Is your bedroom dark? **Yes or No** **If no, why?**_____

Circle if you have any of the following on while you are going to sleep? Radio, Stereo system, TV, White noise, Sound machine, iPod.

Does the above device stay on all night? **Yes or No** **If no, how long?**_____

Do you eat in bed? **Yes or No** Do you read in bed? **Yes or No** Do you work in bed? **Yes or No**

Do you write in bed? **Yes or No**

Are there any pets in the house? **Yes or No** Do they stay in the bedroom with you? **Yes or No**

Do you currently have a special bedtime routine? _____

_____

**If you *do not* sleep alone at night, please have your bed partner answer the following questions.**

Check all that apply that you have witnessed the patient doing while asleep or have noticed about the patient's sleep routine or sleep problem.

_____ Pauses in breathing
_____ Snores
_____ Moves or kicks legs/feet a lot
_____ Talks in their sleep
_____ Sleep Walks
_____ Becomes rigid and / or shakes
_____ Sits up in bed while still asleep
_____ Grinds their teeth while asleep
_____ Nocturia (bedwetting)
_____ Is very restless while sleeping (tossing and turning)
_____ Has a lot of nightmares
_____ Gets up a lot during the night
_____ Has trouble going to sleep
_____ Wakes up a lot at night, but does not seem to have trouble going back to sleep
_____ Wakes up a lot at night, but does have trouble going back to sleep
_____ Falls asleep quite often at inappropriate times (i.e., watching T.V., reading, having conversations with others, riding as a passenger in a car, etc.)
_____ Takes naps (even cat naps). How many times? _____ in any given day

Is there anything else that you feel is important that we have not asked?

_____

_____

_____

_____

_____

_____

_____

Bed Partner Name: _____ Date: _____

PENSACOLA SLEEP DISORDERS CENTER

## HIPPA Authorization for Use or Disclosure of Protected Health Information

Name of Patient: _____ Date of Birth: ____/____/_____ SS#:_____/____/_____

Home Phone #: (_____) _____-_____ Cell #: (_____) _____-_____

_____

Street Address City State Zip

Authorize the following PHI (personal health information) for disclosure:

**Information to be released:**
(X) Abstract/Pertinent information
(X) Sleep Study Results
(X) H & P notes
(X) Physician orders
(X) Patient information sheet

**Purpose of Disclosure:**
(X) Continuing Care
( ) Second Opinion
( ) Changing Physician
( ) Legal
( ) At my (patient) request
(X) Insurance information
( ) Other _____

**READ CAREFULLY:** I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:
☐ Substance Abuse (including alcohol/drug abuse)
☐ Mental Health
☐Psychotherapy Notes
☐HIV related information (including AIDS related testing.
The confidentiality of this record is required under the Florida General Statue, as well as Title 42 of the United States Code. The following applies only to drug/alcohol abuse or treatment information records: Prohibition on Re-Disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation 472-CFR-2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or has otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

You may contact me by **(check all that apply):** ☐ Phone ☐ Written Communication ☐ Work

You may also disclose all information to the following person(s): _____

Relationship:_____ DOB: _____/_____/_____ SS#: _____

1. I understand that this authorization will expire two years from my last date of service/visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying **Janine Albano/ Privacy Officer** at the address indicated below, in writing and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

**Center for Sleep & Medical Diagnostics, Inc.**
**dba: Pensacola Sleep Disorders Center**
**Attn: Janine Albano, Administrator/Privacy Officer**
**6706 N 9th Avenue Unit E1**
**Pensacola, FL 32504**

3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS related information and psychiatric/Mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that may request a copy of this form after I sign it.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and I fully understand the terms and conditions of this consent.

Date: _____ Signature: _____
(If signed by a personal representative, please state relationship/authority to do so)

PENSACOLA SLEEP DISORDERS CENTER

## Medicare Part B
## Determination of Primary Insurance

***Medicare*** wants to know which **ONE** statement is true for **YOU**

I am **OVER** 65**, married** and:

1) My spouse and I are both fully retired. ☐ Medicare is **Primary**

2) **I** work full or part-time**, (my spouse is retired)**, for a company with:
   (a) LESS than 20 employees ☐ Medicare is **Primary**
   (b) MORE than 20 employees ☐ Medicare is **Secondary**

3) **My spouse** works full or part-time **(I am retired)** for a company with:
   (a) LESS than 20 employees ☐ Medicare is **Primary**
   (b) MORE than 20 employees ☐ Medicare is **Secondary**

**I am OVER** 65 and **not married (includes widowed**) and:

4) I am fully retired ☐ Medicare is **Primary**

5) I work full or part-time for a company with:
   (a) LESS than 20 employees ☐ Medicare is **Primary**
   (b) MORE than 20 employees ☐ Medicare is **Secondary**

I am **UNDER** 65, **DISABLED** and:

6) I (have/do not have) health care coverage through a LGHP with and employer who has 100 or more employees.
7) I (have/do not have) health care coverage through anyone else.

**Check any Additional Conditions:**

_____ I have End Stage Renal Disease ☐ Medicare is **Secondary**
_____ I am entitled to Black Lung Benefits ☐ Medicare is **Secondary**
_____ I am entitled to Veteran's Adm. Benefits ☐ Medicare is **Secondary**
_____ COBRA Benefits apply ☐ Medicare is **Secondary**
_____ I was injured in an accident ☐ Medicare is **Secondary**
Type of Accident: _____
Date of Accident: _____
Description: _____
_____
_____

**If none of the above describes your situation, please explain:**

_____
_____
_____
_____

_____ _____ _____
Print Name of Beneficiary/Patient Date Signature of Beneficiary/Patient

*Instructions*: Please read this form carefully, check applicable spaces and sign.

***For Commercial Insurance (i.e.: BCBS, UHC, Tricare, Cigna, Aetna, etc.): Authorization-(Patient Release and Authorization)***

____ I hereby give my authorization for payment of insurance benefits made directly to Pensacola Sleep Disorders Center and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorney fees. I further agree that a photocopy of this agreement shall be as valid as the original.

____ I further authorize the release of any medical information required by my insurance carrier(s)

____ I understand that I am financially responsible for charges not covered by my insurance (Deductibles/co-pays/percentages) A copy of this authorization may be used in lieu of the original

***Medicare Insurance Only: Medicare Authorization-(Patient Release and Authorization)***

____ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct

____ I authorize, Center for Sleep & Medical Diagnostics, Inc., dba: Pensacola Sleep Disorders Center, the holder of medical records and/or other information about me, to be released to the Social Security Administration or its intermediaries or carriers any information to be used, in place of the original, and request payment of medical insurance benefits to the Center for Sleep & Medical Diagnostics, Inc., dba: Pensacola Sleep Disorders Center who accepts Medicare assignment

**Notice: Anyone who misrepresents or falsifies essential information requested on this form, may upon conviction, be subjected to fines and imprisonment under Federal Law**.

***Medicare Insurance Only: Medicare Acknowledgment – For Services, Billing and Reimbursement***

____ I am aware that Medicare and/or Insurance will not reimburse some costs (your 20% co-insurance and any deductibles)

____ I am aware that Medicare Law requires Center for Sleep & Medical Diagnostics, Inc., dba: Pensacola Sleep Disorders Center to make me aware that I will be billed for these non-reimbursable services (your 20% co-insurance and any deductibles either not being covered by your secondary insurance or if Medicare is your only insurance policy)

PLEASE CONTACT THIS OFFICE FOR FINANCIAL ARRANGEMENTS PRIOR TO YOUR SCHEDULED APPOINTMENT.

## ALL PATIENTS:

____ I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING ANY AND ALL CHARGES INCURRED THAT ARE NOT REIMBURSED BY MY INSURANCE COMPANY

____ I CONSENT TO THE COPYING OF MY PICTURE ID/DRIVER'S LICENSE AND INSURANCE CARD(S) FOR THE PURPOSE OF IDENTIFICATION AND BILLING. DECLINING THE COPYING OF THESE ITEMS WILL RESULT IN ALL BILLING BEING BILLED TO ME AND NOT MY INSURANCE COMPANY(S)

WITNESS_____ PATIENT_____ Date _____