PENSACOLA SLEEP DISORDERS CENTER

PATIENT INSTRUCTIONS FOR CARDIORESPIRATORY SLEEP STUDY

In order to have the best chance of falling asleep during your nap study, please follow the instructions listed below:

- We would like you to be slightly sleep deprived so you will be able to fall asleep during your nap study. Therefore, we ask that you please stay awake 1-2 hours later than usual the night before the test and/or get up 1-2 hours earlier than usual the morning of the test. If you can, please, rearrange your sleep pattern in order to make you sleepy enough for your nap.

- **WE RECOMMEND THAT YOU DO NOT DRIVE** because you will be slightly sleep deprived. Please have someone drive you to our center and then pick you up after the test.

- **DO NOT TAKE A NAP** prior to the test.

- We recommend that you eat 1-2 hours before your nap. This can sometimes increase your sleepiness. However, **AVOID ALL ITEMS THAT CONTAIN CAFFEINE SUCH AS COFFEE, TEA, CHOCOLATE, SOFT DRINKS.**

- Allow 3-4 hours for your nap study appointment.

- Wear loose, comfortable clothing.

- Feel free to bring a favorite pillow or blanket.

- Take medication as usual, **with the exception of stimulant medication**. Please wait to take stimulant medication until after the PAP-NAP. If you need to take medication during your nap study, please bring it with you.

- If you think music will help you fall asleep, you may bring an iPod or CD player of your choice.

- Good nasal breathing is very important for this nap study. Therefore, if you have allergies, please treat them as usual. If you have a cold or feel ill, we recommend you reschedule the test.

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** :_____

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

MENTAL IMAGERY SELECTIVE SURVEY (MISS-7)

Imagery or imagination is a process in which we use our mind's eye to picture or feel things. The mind's eye can see many different types of images, including places, faces, memories and other things. Imagery is similar to the way we "see" our dreams. People use imagery differently, depending on their natural skill, their situations or circumstances, or their past experiences, which may have affected their imagery skills. The following questions will help us better understand your imagery skills.

Ability

1. Are you aware of your ability to use your mind's eye to picture images? Yes___ No___

2. While awake, do you notice that you use your mind's eye to see images? Yes___ No___

3. If you were to sit in a quiet and comfortable place, how would you rate your ability to picture images in your mind of a garden, beach or some other pleasant experience or situation?

(Check one below)
_____ Extremely easy to imagine, like a photograph or the real thing
_____ Very easy to imagine
_____ Easy to imagine
_____ Not especially easy or difficult
_____ Difficult to imagine
_____ Very difficult to imagine
_____ Extremely difficult to imagine or picture things in my mind

Barriers

4. Do you ever experience difficulty picturing images in your mind? Yes___ No___

5. While awake, do you experience unpleasant images or intrusive memories, such as, memories that get in the way or memories you try not to have? Yes___ No___

a) If yes, do these negative images sometimes get "stuck" in your mind? Yes___ No___
b) If yes, do you have difficulty getting these images "unstuck?" Yes___ No___

6. Do you have any fear or anxiety when using your mind's eye to view images? Yes___ No___
a) If yes, please explain:_____
_____
_____

7. Before today, have you imagined or "seen yourself" in your mind's eye wearing the PAP mask? Yes___ No___

8. Have you had any negative images in your mind's eye about using the PAP mask? Yes___ No___

PENSACOLA SLEEP DISORDERS CENTER

NOSE – 30

Sound Sleep cannot be achieved without excellent to outstanding nasal breathing. To educate us more about how your nose functions day and night and to learn about your own efforts to improve nasal breathing, please mark the appropriate square matching your answer for each of the following questions.

Part I: Nasal Allergies & Congestion	Never N/A	Rarely	Occasionally	Frequently	Always/ Every Day
My nose is congested, stuffy, or runny during the day					
My nose is congested, stuffy, or runny at bedtime					
I wake up at night with a congested, stuffy or runny nose					
I wake up in the morning with a congested, stuffy or runny nose					
Congestion, stuffiness or a runny nose disrupts my sleep					
I suffer from allergies year round					
My allergies are poorly controlled					
I use non-prescription nasal sprays to treat my allergies					
I use prescribed nasal steroid sprays to treat my allergies					
I use antihistamines to treat my allergies					
I consistently treat my congestion, stuffiness or runny nose					
I use nasal saline washes for my congestion, stuffiness or runny nose					
I take steam showers at bedtime to clear my nasal passages					
I breathe through my mouth because of blockages in my nose					
Keeping my nasal passages clear helps me sleep better					
I have used nasal strips at bedtime to keep my nose open					
My allergy treatments work very well					
Changes in temperature stuff up or make my nose run					
Changes in weather stuff up or make my nose run					
Wind blowing in my face stuffs up or makes my nose run					
My nasal symptoms could interfere with treatment of my sleep problems					

Part II: Airway Anatomy	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
My nose has a deviated septum					
I can breathe through both nostrils about the same					
Sinus problems worsen my nasal breathing					
My tonsils are enlarged					
I might need surgery on my nose or tonsils to breathe better					
My tonsils have been removed					
I have had surgery on my nose					
I have broken my nose in the past					
I mouth breathe during sleep					

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.

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

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's 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 IDENTIFACTION 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 SIGNATURE_____ Date _____