PENSACOLA SLEEP DISORDERS CENTER

Please fill out all information. **This questionnaire should be brought with you when you pick up your home sleep testing equipment at the Pensacola Sleep Disorders Center**. The questionnaire will remain a part of your sleep chart at the center. This information is vital to ensuring accurate testing and to assist in the interpretation of your results.

Patient Information:

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

SSN: _____-_____-_____ Sex: Male/ Female Marital Status: Single Married Divorced Widow

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 # on card)

_____

Group # (short # on card)

_____

Insured name as it reads on the card:

_____

Secondary Insurance Company:

_____

Contract # (long # on card)

_____

Group # (short # 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. **If I fail to return the Home Sleep Testing equipment I will be billed $3,995.00, the cost of replacement.** 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 child is under 18 yrs. old) Date

PENSACOLA SLEEP DISORDERS CENTER

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 or HAY FEVER	____ MITRAL VALVE PROLAPSE	____ DEVIATED NASAL SEPTUM
____ COPD or EMPHYSEMA	____ GOUT	____ ASTHMA
____ IRRITABLE BOWEL SYNDROME	____ DIABETES or "SUGAR"	____ 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?

_____

_____

_____

Please list any other significant medical conditions:_____

_____

_____

Please list all surgeries you have had:_____

_____

_____

Please list all of the medication you are currently taking:

Medication	**Dosage**	**Medication**	**Dosage**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6706 N. 9th Avenue, Unit E1 ● Pensacola, FL 32504 ● Phone: 850-473-9709 ● Fax: 850-476-9519

Patient Name: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____ **Rec. ID:**_____

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

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Patient Name: _____ **DOB:** ___/___/_____ **Date:** ___/___/_____ **Rec. ID:**_____

PENSACOLA SLEEP DISORDERS CENTER

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

Tech Signature_____ Patient Signature_____ Date _____