PENSACOLA SLEEP DISORDERS CENTER
MAINTENANCE OF WAKEFULNESS TEST (MWT) INFORMATION AND GUIDELINES

Please read carefully and fill in the applicable information.
We ask that this paperwork be completed prior to your appointment to ensure you are properly informed and prepared.

Name: _____ Date: _____Time: _____

Primary Insurance: _____ Secondary Insurance: _____ Policy: _____/_____
Primary Secondary

Co-Pay: $_____ Deductible: $_____ Your Policies Percentage Amount $_____

Amount to bring in the night of your study: $_____. **Failure to bring in this amount will result in you being sent home and charged a $100.00 inconvenience fee.**

Co-Pay, Deductible, and Percentages are estimates, received from you insurance carrier. ALL insurance carriers give the following disclaimer: "The information given to PSDC does not guarantee payment and or the benefits verified. Claims are subject to review. All terms, conditions, and limitations of the patient's policy will apply." Please know your policy. All co-pays, deductibles, and percentages will be collected upon arrival. Please bring your insurance card(s) and a picture ID with you. PLEASE DO NOT ARRIVE EARLY FOR THIS APPOINTMENT. LEAVE ALL VALUABLES AT HOME. PSDC DOES NOT ASSUME ANY RESPONSIBILITY FOR LOST OR STOLEN VALUABLES BROUGHT TO THE FACILITY. We accept the following forms of payment: checks, cash, and money orders, Visa, MasterCard, Discover and Amex. Cash payments are only accepted in the exact amount. The technologists are unable to provide change.

*****There is an administration fee for appointments that are not cancelled within 48 hours. You will be billed a fee of $300.00 if you fail to cancel your appointment within the allotted time or fail to show for your appointment.*****

1. Your physician has requested that you undergo an MWT study. This test is designed to assess your symptoms of excessive daytime sleepiness. You will need to arrive at the facility by 7:00 AM on your scheduled date and expect to remain at the facility the majority of the day. Eat breakfast prior to your arrival for the MWT study.

2. The MWT is used to assess wakefulness. Sensors are applied to the skin on your scalp, face, and shoulder. Please bathe and shampoo your hair prior to arrival. Do not apply any face or body moisturizer, hair spray, or gel. The MWT consists of a series of wake trials. These trials are conducted in 2 hour intervals. During these 2 hour intervals you will need to maintain wakefulness. This test will be comprised of 4 testing sessions, 40 minutes in length for each test, where you will be asked to try to stay awake (without physical activity) while sitting in a darkened room. You may not leave the testing area during that time, or have any caffeine during this test. The test will conclude between 2 to 4 p.m. You will be required to either bring a lunch or have someone bring you lunch. Lunch **is not** provided.

3. A URINALYSIS WILL BE PERFORMED PRIOR TO THE MWT TEST, because certain medications can alter the results of the test. Please bring any medications in their original pill bottle, whether prescribed by a physician or over the counter if you will be self-administering medications during your study. **DO NOT TAKE ANY MEDICATIONS WITHOUT FIRST CONSULTING YOUR TECHNOLOGIST.** In the event you do take your medication without the consultation of your technologist you will be sent home and will need to reschedule your appointments. This will result in a double charge. **Certain medications are to be discontinued and NOT taken 2 weeks before your appointment. Some medications may result in inaccurate test results. Please call your referring physician to verify which medications, if any, that you cannot take for this test.** Please also consult your physician about any medications that are stimulants or sedatives. The following are examples of some of the prescriptions that should not be taken: Ambien or a similar sedating medication; Nuvigil, Provigil, Ritalin, Vyvanse or any other stimulant.

4. The sleep room you will be in is just like a regular bedroom with a double bed, a chair, and television. You will remain in the same room for the entire time you are at the facility. During the 2 hour intervals you are able to walk around or watch television. During the 2 hour wake periods, patients tend to get a little bored, so we suggest that you bring enough items to occupy your time. You may bring books or magazines to read, crossword puzzles, laptops, or tablets, or anything you may like to do that will help pass the time.

5. **Our billing services are provided by Quest National Billing Services.**
6. **Reading Physicians bill your insurance separately. Their charges are between $150.00 and $350.00 depending on the study type.**

7. We will be more than happy to answer any questions. You may contact our day staff, Monday-Thursday between the hours of 8:00am and 5:00pm.

_____ _____
Patient Signature Date

PENSACOLA SLEEP DISORDERS CENTER

Please fill out all information. This questionnaire should be brought to your first appointment at The Pensacola Sleep Disorders Center. The Questionnaire will remain a part of your Sleep Chart. This information is vital to ensure accurate testing and to assist in the interpretation of your results.

General Information

Patient Name:

First: _____M:_____ Last: ____Age: _____ **Date of Birth**: ____/____/_____

SSN: _____ **Sex**: Male or 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**: _____

Daytime Phone: _____ **Evening 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. 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
MAINTENANCE OF WAKEFULNESS PRE-TEST QUESTIONNAIRE

1. When were you diagnosed with sleep apnea? _____
2. Were you set up on a CPAP or other type of sleep apnea therapy machine? _____
   If no, skip questions 3-6.
   If yes, how long have you been using your sleep apnea machine? _____
3. How many hours per night do you use your CPAP? _____
4. Do you wake up refreshed in the morning after using your machine all night? _____
5. Are you satisfied with your sleep apnea treatment? _____
   If no, why? _____
6. When using your CPAP, do you feel sleepy at all during the day? _____
   If yes, about what time during the day do you get sleepy? _____
7. Do you feel your sleep disorder is affecting your life? _____. If yes, how so?
   _____
8. 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
__move arms during sleep
__legs uncomfortable at bedtime
__vivid dreams
__start dreaming when falling asleep
__act out your dreams
__nightmares or night terrors, if yes, do you remember them? Yes or No

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 or No If yes, who and what disorder? _____

_____

_____

Do you have or have you had cancer? Yes or No
Current status? _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 and 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** from me

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

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

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

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

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

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** for me
_____ I am entitled to Black Lung Benefits. ☐Medicare is **Secondary** for me
_____ I am entitled to Veteran's Adm. Benefits. ☐Medicare is **Secondary** for me
_____ COBRA Benefits apply. ☐Medicare is **Secondary** for me
_____ I was injured in an accident. ☐Medicare is **Secondary** for me
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

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

Patient Name: _____ DOB: _____ Date: 1/4/2018 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.

WITNESS_____PATIENT SIGNATURE_____ Date _____