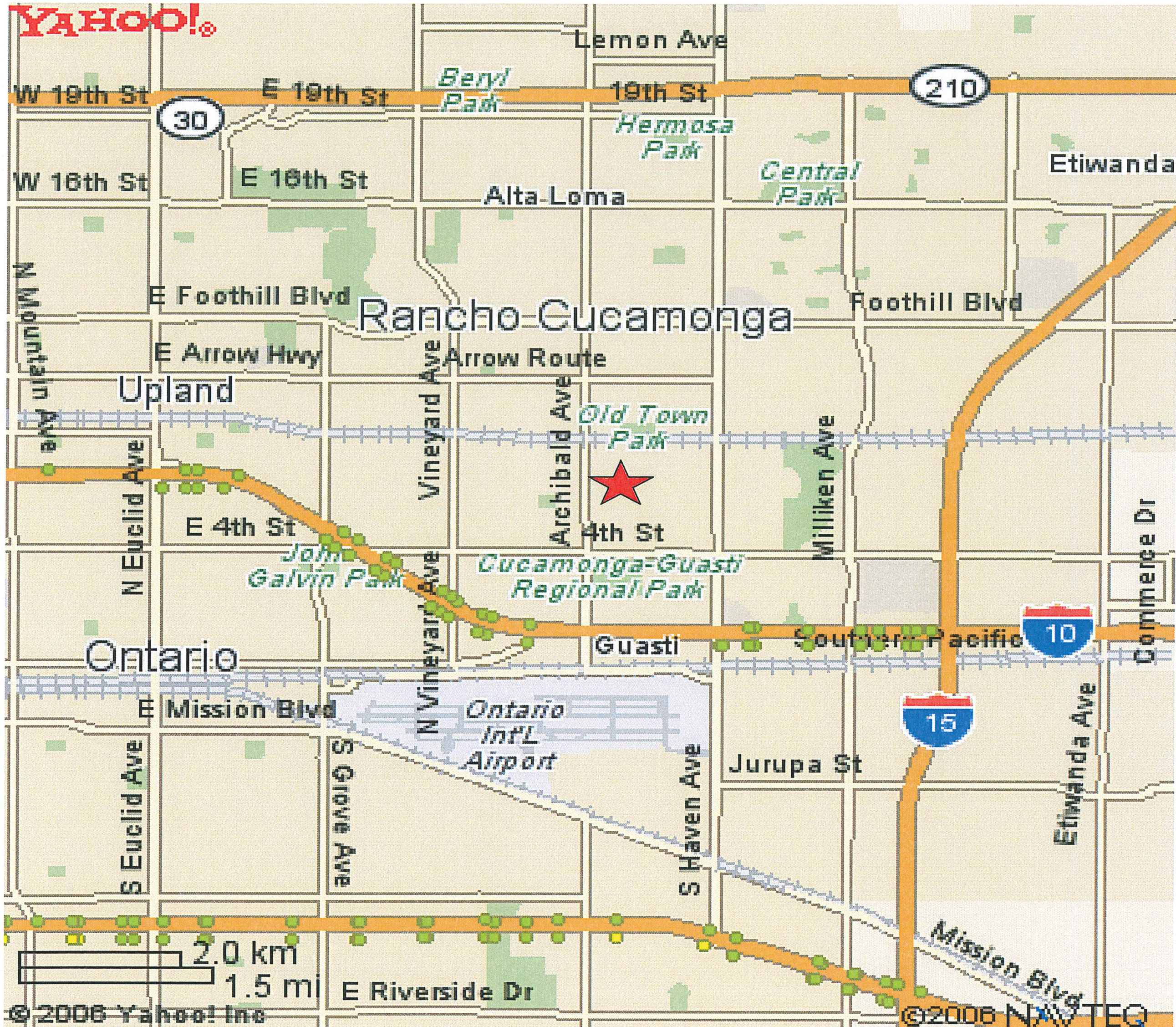
Patient Packet

#RAE

AMERICAN SLEEP CENTERS
9439 Archibald Avenue, Suite 105
Rancho Cucamonga, CA 91730
(909) 987-3100



I-10 Freeway East
Exit on Archibald Avenue
Left on Archibald Avenue

I-10 Freeway West
Exit on Archibald Avenue
Right on Archibald Avenue

210 Freeway West
Exit on Archibald Avenue
Make Left on Archibald Avenue
Towards Ontario Airport

210 Freeway East
Exit on Archibald Avenue
Make right on Archibald Avenue
Towards Ontario Airport

15 Freeway South
Exit 4th Street
Right on 4th to Archibald
Right on Archibald

15 Freeway North
Exit 4th Street
Right on 4th to Archibald
Right on Archibald

Date: ____________________

ACQUAINTANCE FORM

Referring Dr.: ________________________

PLEASE COMPLETE IN BLUE OR BLACK INK

PATIENT INFORMATION

Name of Patient: ________________________________ Male___ Female ___ Age ____ Date of Birth: ____________

Home Address: __________________________________City: ____________________St: ______Zip:__________

Home Phone: (Area Code)_______________ Cell Phone: _______________ Social Security #: _______________

Circle One: Single Married Divorced Separated Widowed E-Mail Address:________________________________

Employer Name (if applicable): ____

Employer's address: __________________ City: ____________ St: ____ Zip: _________ Work Phone: ___________

Nearest Relative (not living with patient): ____________________ Relationship: _________ Phone: ________________

SPOUSE INFORMATION

Name: _______________________________ Date of Birth: _________ Soc. Sec #: ____________________

Home Address: ______________________________ City: ____________________ St: ___ Zip: _________

Home Phone: (Area Code)____________________ Cell Phone: (Area Code) ____________________

Employment: ____ Business Phone: ______________________

Employer's address: ___________________________________ City: ____________ St: _____ Zip: ________

INSURANCE INFORMATION: **PLEASE GIVE ALL ACTIVE INSURANCE CARDS TO RECEPTIONIST/TECHNICIAN**

Name of Company: ______________________ Name of Primary Subscriber: ______________________________

Subscriber's Social Security number: __________________ Insurance ID number: ____________________________

PERSONAL VALUABLES: I understand that American Sleep Centers does not maintain a safe or safekeeping of money and valuables and I agree American Sleep Centers shall not be liable for loss or damage to any money, jewelry, glasses, dentures, documents, cell phones or other personal electronic devices, documents, or other articles of value.

WE DO FILE YOUR SERVICES TO YOUR INSURANCE COMPANY AUTOMATICALLY.
PLEASE PROVIDE CURRENT AND CORRECT ADDRESS AND INFORMATION TO EXPEDITE THIS PROCESS.

Thank you for choosing American Sleep Centers for a good night's sleep.

9439 Archibald Avenue, Suite 105
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www.americansleepcenters.com

American Sleep Centers
Assignment of Benefits and Financial Agreement

Thank you for choosing American Sleep Centers. We are committed to treating our patients in a professional and caring manner. This statement of our financial policy defines the patient's (your) financial responsibility to American Sleep Centers and which we require you, as the patient (or legal guardian or parent), to read and sign before we can render any services.

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered, assigns to American Sleep Centers the following rights, power, and authority:

ASSIGNMENT OF BENEFITS: American Sleep Centers is assigned the right to any cause of action that exists in my favor against any insurance company or other persons or entity to the extent of your bill for total services, including the exclusive, irrevocable right to receive payment directly for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company or other entity. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. American Sleep Centers is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me for treatment rendered by American Sleep Centers, you are hereby rendered demand to pay the provider directly in full the bill for services rendered by American Sleep Centers following your receipt of such bill for services to the extent such bills are payable under the terms of my policy for benefits, less any amounts that I owe personally which are not payable under the terms of my policy benefits.

STATUTE OF LIMITATIONS: I waive the right to claim any Statute of Limitations regarding claims for services rendered by American Sleep Centers.

ATTORNEY FEES: I agree to pay for reasonable costs of collection (both pre and post judgment) for services rendered by American Sleep Centers if my account is assigned to an outside agency for pursuit of collection of unpaid balances. The undersigned agrees to pay all attorney fees, court costs, filing fees, and interest upon the unpaid balance at that rate permitted by law, as assessed to the undersigned by any agency retained to pursue this matter with or without suit.

All authorizations are applicable for any services rendered by a medical provider billing separately for their services at American Sleep Centers.

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT OR IS DULY AUTHORIZED TO EXECUTE THE ABOVE AND TO ACCEPT ITS TERMS.

Printed Name: ______________________________ Signed: ______________________________

Witness: ______________________________ Date: ______________________________

Effective 4/26/2011

American Sleep Centers

Patient Consent / Medical Release / Receipt of Privacy Practices Form

PLEASE COMPLETE IN BLUE OR BLACK INK

Patient Consent

I, ________________________, am requesting American Sleep Centers and the doctors who practice there to test me for possible sleep disorders. I understand that, as a patient, I am required to authorize American Sleep Centers for such service and am hereby authorizing such tests. I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that American Sleep Centers will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies upon written request. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. I also acknowledge that I have consulted my physician and understand the nature of the test(s) that I am about to undergo with American Sleep Centers. By signing this document, I consent to the tests that will be performed on me by the staff of American Sleep Centers.

Patient's Signature: ____

Patient Authorization for Release of Medical Information

I, ________________________, give American Sleep Centers my permission to release to the following family member (s)/ friend (s) information from my medical record in my absence. This release will apply to American Sleep Centers, any doctors and their staff who provide services to American Sleep Centers, and any durable medical equipment company (DME) staff used to supply medical equipment to me. Unless otherwise noted this release allows the above entities to leave messages on my answering machine/voice mail, with whomever answers my home phone, to call me at work, and to communicate with me through email or the American Sleep Centers web site portal. I understand that without my signed consent, no communication may occur through email, including receiving copies of test reports.

Patient's Signature: ____

NAME	RELATIONSHIP
________________________	________________________
________________________	________________________
________________________	________________________

EXCEPTIONS: ____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, ________________________, have received a copy of the Privacy Practices of American Sleep Centers.

Patient's Signature: ______________________________

Witness: ______________________________

Today's Date: ____________________

PATIENT INSTRUCTION SHEET

INSTRUCTIONS

- ⇒ Your hair should be clean and "undone". Electrode gel will be used to adhere leads to your scalp. This is not painful but gel will need to be washed out the following morning.
- ⇒ Bring your insurance card
- ⇒ Pack as if you are spending the night in a hotel
- ⇒ Eat supper before you come – we do have snacks and caffeine-free drinks
- ⇒ No caffeine after 9 am the day of the test
- ⇒ Bring any medications you regularly take at night
- ⇒ Bring comfortable clothing (P.J.s, sweats, NO SILK OR SATIN, etc.)
- ⇒ We do have cable TV but you may bring reading material, handiwork, etc.
- ⇒ Arrive at your scheduled appointment time, either 8:30 or 9:30 pm, unless other arrangements are made with American Sleep Centers. (Refer to your welcome letter for specific arrival time)
- ⇒ Departure time is between 6:30-7:00 am; please, tell the technicians if you need to leave earlier
- ⇒ You may bring your own pillow though we do have pillows
- ⇒ Shower facilities are available
- ⇒ Check your room upon departure; lost and found items are kept for 2 weeks.
- ⇒ The use of electronics may interfere with equipment and it may be necessary to turn them off once the study commences

WHAT TO EXPECT

Upon your arrival you will be greeted by a technician who will escort you to your room. The technician will explain the procedure and what to expect during the night. Prep, and if needed, mask fits take between 30 and 45 minutes with lights out around 10 pm. Wake up time is between 6 and 6:30 am. Electrode gel will be used to adhere leads to your head, lower legs, chest and face.

If you are arranging transportation for pick up in the morning, please arrange for your ride to be here for you by 6:30 am.

When following American Academy of Sleep Medicine and insurance (including Medicare) guidelines, Obstructive Sleep Apnea testing is normally a two night procedure: one night to diagnose this condition, a second night to determine the appropriate pressure to correct your apnea and keep your oxygen level normal. Following guidelines these two studies may occasionally be combined into one sleep study.

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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.**

Allowed Uses and Disclosures of Your Medical Information:

- Treatment - such as ordered diagnostic tests, other health care providers (example: Primary Care Physicians, pharmacies, etc.)
- Payment - such as submitting billing information to your insurance company, disclosures to consumer reporting agencies, (limited to specific identifying information about individual, his or her payment history, and identifying about the covered entity.)
- Health Care Operations - such as quality assurance reviews, coordination of care, and eligibility verification.
- Public Health Activities - such as child abuse or neglect.

In addition to the above, your medical information may be used or disclosed for emergency treatment, when we are required by law to treat you, we attempt to obtain consent, and are to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restriction on certain uses and disclosures; however, we are not required to agree to any restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request or review out entire policy.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and obtaining written acknowledgement.
- Abiding by terms of this notice.
- Providing written notice of any changes to this notice.

Complaints:

If you believe that your privacy has been violated and would like to file a complaint with us, please provide written notice of how you believe we violated your privacy to Kymberly Black, Director of Operations. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and we will not retaliate for any allegations you make.

Authorizations:

Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another insurance company (apply for life insurance), or a relative. You may revoke any authorization you make at any time except to the extent that it is already relied on.

Patient contact:

We do need to contact you to provide test results, appointment reminders, and treatment information. If you want to request an alternate or confidential communication, please speak with our office staff to get this taken care of.

To obtain information contact us at (909) 987-3100.

Effective April 14, 2003
Revised May 13, 2011

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SLEEP QUESTIONNAIRE

PLEASE COMPLETE IN BLUE OR BLACK INK

This questionnaire may seem lengthy, but it is important that you fill it out as accurately as possible.

Some of the questions may not pertain to your specific complaint, but still answer them as best as you can.

The questionnaire is a broad based screening tool that is very helpful to us and your physician.

It may be helpful to consult family members on some questions. All information contained in this questionnaire is held in strict confidence.

PLEASE COMPLETE THE QUESTIONNAIRE BEFORE YOUR APPOINTMENT.

THANK YOU.

Please fill this out prior to your visit. A family or roommate questionnaire is to be filled out on page two. The sleep log must be done in the A.M. each day. Please do not fill the whole week's data all at once. Doing so will destroy the value of this information in helping to diagnose your problem. Thank You.

Name:______________________ Occupation:____________ Age:_____ Birthdate:________

My main sleep complaint is: Briefly describe problem:______________________________

_____Being sleepy all day

_____Trouble sleeping at night______________________________

_____Insomnia

_____Can't sleep when I want to______________________________

_____Unusual behavior in sleep

_____Other sleep problems______________________________

When did your problem begin?______________________________

Has it been getting worse?______ No ______Yes. For how long?______________________________

Height________ Weight________ Weight in High School____________ Neck size__________

Check all that apply:

	NO	YES	(Please explain or describe)
1. I have a medical problem that disturbs my sleep	____	____	______________________
2. I do shift work	____	____	______________________
3. My sleep problem disturbs my sex life	____	____	______________________
4. I sleep better away from home	____	____	______________________
5. I read/watch TV before falling asleep	____	____	______________________
6. I wake up often at night	____	____	Soon after asleep___ Middle of Night___ Too early/can't go back to sleep____
7. My weekend sleep habits are different	____	____	Stay up late___ Get up late____ Better____ Worse_____
8. My sleep is disturbed by my environment	____	____	Pain____ Light____ Noise____ Bedmate____ Cold____ Warm____ Other:______________
9. I will nap daily or almost every day	____	____	______________________
10. I drink coffee/tea/cola	____	____	How much of each? _____Cups/day _____Cans/day _____Glasses/day
11. I use cigarettes/alcohol	____	____	How much of each? _____Packs/day _____Drinks/day _____Drinks/week
12. I have allergies	____	____	To what things?______________

Past Medical History: Check all that apply to you. Give dates or duration necessary(i.e., Hypertension X, 1991)

Hypothyroid	_____	Diabetes	_____
Heart Trouble	_____	Seizures	_____
Hypertension	_____	Arthritis	_____
Hiatal hernia	_____	Cancer	_____
Heartburn	_____	Tuberculosis	_____
Emphysema	_____	Kidney trouble	_____

Hospitalizations, surgeries, other medical problems:

____

____

____

____

List all medications you may use, including intermittent use of over the counter medication:

	Name	Amount	How Often?	Reason
Example:	*Tylenol*	*2 pills, 325 mg ea*	*twice a day, twice a week*	*tension headache*

1.______________________________

2.______________________________

3.______________________________

4.______________________________

Please rate the following statements by circling the appropriate number

1= Never (strongly disagree) 2=Rarely (disagree) 3=Sometimes (not sure) 4=Usually (agree) 5=Always (agree strongly)

Statement	Rating
I am told I snore loudly and disturb others	1 2 3 4 5
I am told that I hold my breath (stop breathing) in my sleep	1 2 3 4 5
I awaken suddenly gasping for breath, unable to breathe	1 2 3 4 5
My snoring or breathing problem is much worse if I sleep on my back	1 2 3 4 5
my snoring or breathing problem is much worse if I fall asleep right after drinking alcohol	1 2 3 4 5
I sweat a great deal at night	1 2 3 4 5
I have a problem with my nose blocking up when I am trying to sleep (allergies, infections)	1 2 3 4 5
I often have problems with sleepiness while I am driving	1 2 3 4 5

Statement	Rating
I have trouble getting to sleep at night	1 2 3 4 5
At bedtime, thoughts race through my mind	1 2 3 4 5
At bedtime, I feel sad and depressed	1 2 3 4 5
My sleep is disturbed by sadness or depression	1 2 3 4 5
I have been unable to sleep at all for several days	1 2 3 4 5
I am unhappy about loving relationships in my life	1 2 3 4 5
I often have nightmares or am told that I will scream and sob in my sleep	1 2 3 4 5

Statement	Rating
When falling asleep I feel unable to move (paralyzed)	1 2 3 4 5
I feel unable to move)paralyzed) after a nap	1 2 3 4 5
I am often unable to move when I am waking up in the morning	1 2 3 4 5
I get "weak knees" when I laugh	1 2 3 4 5
I get sudden muscular weakness when I'm angry or have strong emotions	1 2 3 4 5
I have dream- like images (hallucinations) when I awaken in the morning or after a nap	1 2 3 4 5
Now, I am very sleepy during the day and I struggle to stay awake	1 2 3 4 5
I got bad grades in school because I was too sleepy	1 2 3 4 5
I now have trouble doing my job because of sleepiness or fatigue	1 2 3 4 5
I often have to let someone else drive the car because I am too sleepy to do it	1 2 3 4 5

Statement	Rating
I wake up often during the night	1 2 3 4 5
When falling asleep, I have "restless legs" aching, crawling, unable to keep legs still	1 2 3 4 5
at night my heat pounds, beats rapidly, or beats irregularly (palpitations)	1 2 3 4 5
I feel that I have insomnia	1 2 3 4 5
I smoke tobacco within two hours of Bedtime	1 2 3 4 5

Spouse, Roommate, Family Questionnaire

Check any of the following behaviors you have observed the patient doing while asleep

	Never	Occasionally	Frequently	Nightly
Light snoring	____	____	____	____
Loud Snoring	____	____	____	____
Gasping for breath	____	____	____	____
Snorts	____	____	____	____
Pauses in breathing	____	____	____	____
Twitching of legs	____	____	____	____
Grinding of teeth	____	____	____	____
Sleep talking	____	____	____	____

	Never	Occasionally	Frequently	Nightly
Bedwetting	____	____	____	____
Sitting up asleep	____	____	____	____
Head rocking/banging	____	____	____	____
Biting tongue	____	____	____	____
Very/rigid/shaking	____	____	____	____
Sleep walking	____	____	____	____
Getting out of bed asleep	____	____	____	____

Describe any of the above in more detail if necessary (like, how long has it been happening?)

____

____

____

AMERICAN SLEEP CENTERS

SLEEP TENDENCY SCALE

NAME:________________________________ **DATE:**________________________________
AGE__________ **MALE**_______ **FEMALE**_______

HOW LIKELY ARE YOU TO FALL ASLEEP/DOZE IN THE CIRCUMSTANCES LISTED BELOW? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO FIGURE HOW YOU WOULD REACT. USE THE **MOST APPROPRIATE NUMBER BELOW TO DESCRIBE YOUR REACTION.**

0 = NO CHANCE OF DOZING
1 = SLIGHT CHANCE OF DOZING
2 = MODERATE CHANCE OF DOZING
3 = HIGH CHANCE OF DOZING

SITUATION	**CIRCLE CHANCE OF DOZING BELOW**
SITTING AND READING	0 1 2 3
WATCHING TV	0 1 2 3
SITTING, INACTIVE IN A PUBLIC PLACE, (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 THE CIRCUMSTANCES ALLOW IT	0 1 2 3
SITTING AND TALKING TO SOMEONE	0 1 2 3
SITTING QUIETLY AFTER LUNCH, WITHOUT ALCOHOL	0 1 2 3
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0 1 2 3

Total score – add all responses __________