 **Premier Sleep Disorders Center**

#  Sleep sound • Sleep safe • Sleep well l

**111 North Park Drive**

 **Victoria, Texas 77901**

 **Phone: (361) 572-9654 Fax: (361) 485-2233**

1. On the night of your scheduled sleep study, report at 7:30 P.M. to the Premier Sleep Lab located at 111 Northpark Drive (*off of Mockingbird)*. Please ring the doorbell at the front door and a technologist will greet you and register you for your night in the sleep lab.
2. Please be sure to begin filling in the sleep log, making the last full day of data entered the day of your sleep lab appointment.
3. Shampoo your hair prior to the test. **DO NOT** use any conditioners, spray, gels or mousse on your hair.
4. **Females**- Make sure your face is free of excess make-up oils.
5. **Males**- Please shave any recent facial stubble growth. Full beards can be worked around.
6. Bring loose-fitting comfortable pajamas or night-wear, preferably a two-piece, as well as any toiletries. Also bring a change of clothing for the next day.
7. If you prefer to sleep with a special pillow, you may bring it with you.
8. If you normally read before retiring for the night, you may bring a book, magazine or newspaper. A television will be in your room as well for your convenience.
9. Take all your usual medications. **Bring any medication you know you will need with you on the night of your sleep appointment.**
10. **Avoid caffeine or alcohol**, after 2:00 p.m., the day of your test. This includes colas, coffee, chocolates.
11. The sleep study will conclude at approximately between 6:30-7:30 A.M. the following morning.
12. Premier sleep lab **strongly** recommends that every patient make arrangements for someone to drive them home following the test to avoid the risk of falling asleep while driving.
13. It will be approximately two weeks before a final report is provided to your physician.

Please call (361) 572-9654 at least 24-48 hours in advance if you are not able to keep your scheduled appointment.

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*Welcome! Please read the following document carefully, then sign below and return the document to the technician; should you require a copy for your personal records, please ask the technician to make you one.*

 The physicians and staff at Premier Sleep Disorders Center appreciate your choice of our Center to evaluate the cause of your sleep disturbance. We hope that this experience will be as comfortable as possible. Please inform the technicians if you have any special needs (e.g., handicapped, extra blankets, fan, etc.) or if you encounter any problems during your stay here.

 The field of sleep medicine is highly specialized and requires technical expertise. Over 16 different pieces of information about signals your body produces are recorded on high-speed computer while you sleep. This material must be first scored by a special technician, and is then reviewed by a sleep specialist in detail to reach the proper conclusions. The final interpretation of your study is based on these recordings, the technician’s observations, your history (as provided by the sleep history questionnaire) and your referring physician’s information. **Please follow up with your referring physician for information regarding the results of your test.**

 A sleep specialist will review the sleep study and render a professional opinion about its significance and the diagnosis reached from the evaluation. **You and/or your insurance company will receive charges from both the Sleep Center for the sleep study and from the interpreting physician.**

 Your physician may request a consultation with a member of our Sleep Center staff prior to or after a sleep study is completed.

 Please let us know if we can help you in any other way. We appreciate your completion of the Evaluation of Services form, which allows us to gauge our performance. **Do not hesitate to contact our management staff operations manager or our medical director, if you have any concerns.**

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ONE NIGHT OR TWO? WHAT IF MY DOCTOR**

 **ORDERS A SPLIT NIGHT SLEEP STUDY?**

**What is a split night sleep study?**

A split night study is a one night sleep study that is a combination of two separate sleep tests. Typically sleep testing includes a diagnostic night in which a patient’s sleep is monitored and potential sleep disorders are identified. A second night sleep study may follow, which allows the patient to undergo treatment for their sleep disorder under the supervision of sleep professionals. Commonly, PAP (positive airway pressure) is titrated for patients identified with sleep apnea or clinically significant sleep disordered breathing.

**How Do I qualify for a split night sleep study?**

In order for a split night study to be performed, a patient should meet certain qualifying criteria. Medicare and Medicaid guidelines stipulate that in order for a patient to qualify for treatment of their sleep disorder with PAP therapy, they must undergo an attended sleep study and have a minimum of two hours of recorded sleep with an apnea/hypopnea index of equal to or greater than 15 events per hour. In other words, a patient should have cessation of breathing occurring at least 15 times an hour during two hours of recorded sleep. Waking periods, or periods that the patient may be in the bathroom are not included in the two hour period.

In a sleep lab setting, it is not always possible for a patient to obtain the minimum two hours of sleep prior to 1:00 in the morning. This is typically the cut-off time, as there needs to be sufficient time allowed for adequate application and titration of the PAP therapy.

***This qualifying criteria must be met in order for payor sources such as Medicare to reimburse or pay for any DME (durable medical equipment) prescribed after testing.***

**What will happen during the split night study?**

Approximately at 1:00 in the morning, a technician will enter the room and apply a nasal mask which is connected to a PAP unit that will blow room air at varying pressures, depending on the severity of a patient’s sleep disordered breathing. The patient’s sleep apnea will be monitored and the pressures are adjusted until all snoring and sleep apnea has been eliminated during the patient’s five separate stages of sleep.

**What will happen after the split night study?**

A sleep specialist will read the exam and a final report will be provided to your referring physician.

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Consent to Perform Sleep Studies ( Polysomnography, Titration, MSLT’s, MWT)

An overnight sleep study or polysomnogram is a recording of brain waves (EEG), eye movements, muscle activity from the chin, the ribs, and the lower legs, cardiac activity, and blood oxygen concentration during a regular night of sleep. Information gleaned from a sleep study includes recorded assessments of the overall quantity and quality of sleep, as well as the presence of disruptive snoring and any atypical respiratory, cardiac, and muscle activity. Unusual or abnormal brain activity in sleep such as seizure patterns may also be obtained from the patient. From such results, doctors are able to make accurate diagnoses of sleep disorders and to recommend appropriate treatment(s) for their patients. The information is gathered through non-invasive surface electrodes attached to various body surfaces including the scalp, face, chin, chest and lower legs. Small sensors are also placed under the nose and on the finger. A pair of bands is placed around the chest and abdomen to monitor breathing efforts. No part of this procedure should be painful, although occasionally some patients may consider the recording equipment to be a nuisance or minor discomfort. ●

During some overnight sleep studies, patients may undergo a trial of nasal continuous positive airway pressure (CPAP) to treat obstructive sleep apnea. CPAP/BiPAP is a device that introduces a stream of pressurized air through a mask, which is placed over the nose (and sometimes mouth) and assists in breathing during sleep. ●

**●I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of the test(s) or procedures(s) specified above.**

**●I understand that in the event of a medical emergency I will be transported to the Emergency Room.**

**●The undersigned hereby authorizes the technologist to photograph and/or videotape, or permits others persons to photograph and/or videotape, the below mentioned person while under the care of the sleep center. He/She agrees that the originals and/or prints prepared from such photographs and/or videotapes may only be used for clinical purposes. *Please initial* YES(I consent)\_\_\_\_\_\_\_\_\_\_** **No(I do not consent\_\_\_\_\_\_\_**

**●The undersigned hereby authorizes the technologist to perform polysomnography, titration, multiple sleep latency testing, and/or maintenance of wakefulness testing as requested by the referring physician.**

**●The sleep center is not responsible for any personal items brought to or left on the premises.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Patient’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Witness Date**

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**Financial Policy**

● Our office will file your claims to your insurance carrier(s) as a *courtesy* to you. Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains ***your responsibility***; thus you are responsible for follow-up communication with your insurance company should there by a problem in processing a claim.

● Our practice is committed to providing the best treatment for our patients and we charge what is usual, customary, and reasonable for the geographic areas we cover.

● Concerning *payment arrangements,* a budget plan consists of the account being paid in full in three monthly payments unless other arrangements are made. In the event you are a self-pay account, arrangements must be made prior to your appointment or testing date. We require that thirty (30) percent of the charges be paid prior to the service being performed. The remaining balance will be subject to the payment arrangement terms listed above. We accept cash, checks, VISA, MasterCard, money orders, for all payments.

● If your account must be turned over to an outside collection agency, a collection agency fee equal to thirty-three percent of your account balance will be added to the existing balance.

● If you must reschedule, we require a 24-hour notice. Tests scheduled for Saturday or Sunday must be cancelled by 5:00 pm on Friday. If you cancel or miss your appointment without the required notice, we must assess a $50.00 cancellation fee. *This will not be covered by insurance.*

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Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witness Date

If the patient is unable to sign, express consent, or is a minor, please complete the following:

Patient’s condition is such that he/she is unable to sign.

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient is a minor, \_\_\_\_\_ years of age.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signature of close relative Insured/Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witness Relationship Date

**PLEASE BRING THIS SIGNED COPY OF OUR FINANCIAL POLICY WITH YOU TO YOUR APPOINTMENT**

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**Authorization for Release of Information/Health Care Information**

I authorize Premier Sleep Disorders Center and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records including, without limitations, sleep history and sleep consultations, sleep lab reports, physician progress notes, technologists notes, during this outpatient visit to the organization which is or may be liable for payment of charges associated with my care for all other purposes of benefit of payment. •

I acknowledge that date from my patient records will be accessible to all health care providers participating in my care or treatment, including, but not limited to physicians, sleep technologists, durable medical equipment companies, and other health care agencies involved in my care during and after my care at Premier Sleep Disorders Center. •

I further acknowledge that my medical record will be utilized in the sleep labs performance improvement, quality assurance, peer review, and other similar processes of studies. I also acknowledge that my medical records will also be made available to governmental agencies as required by law. •

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device I may receive.•

**Assignment of Benefits:**

I or my agent, herby authorize direct payment be made to **Premier Sleep Disorders Center** any insurance benefits payable to or in my behalf for the outpatient services rendered. It is agreed that payment to Premier Sleep Disorders Center by a medical insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this assignment and that all amounts are due upon request. •

This assignment will remain in effect until revoked by me in writing.

 I hereby authorize said assignee to release all information necessary to secure payment. •

A photocopy of this assignment is to be considered as valid as an original. •

**Notice of Separate Billing:**

I hereby acknowledge that I was informed that there are sleep study interpretation fees that may be **billed separately** from Premier Sleep Disorders Center for testing performed in the sleep center.

**I hereby certify and state that I have read, and that I fully and completely understand this Authorization for Release of Information/Health Care Information and Assignment of Benefits, and that I have signed this Authorization for Release of Information and Assignment of Benefits, knowingly, freely, and voluntarily.**

***A copy of this Patient Agreement and Consent shall be considered the same as original.***

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT DATE

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 WITNESS DATE

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Premier Sleep Disorders Center Privacy Notice.

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**Print Name Unique Identifier**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature or Personal Representative's Signature Date**

If Personal Representative, describe relationship

*For office use only:*

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign.

□ Communications barriers prohibited the acknowledgment.

□ An emergency situation prevented us from obtaining acknowledgement.

□ Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I*

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**NOTICE OF PRIVACY PRACTICES**

This Notice is effective March 26, 2013

**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*

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

* Post the new Notice in our waiting area.
* Have copies of the new Notice available upon request. (Please contact our Privacy Officer at **(361)572-9654** to obtain a copy of our current Notice).

The rest of this Notice will:

* Discuss how we may use and disclose medical information about you.
* Explain your rights with respect to medical information about you.
* Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at **(361 572-9654.**

**WE MAY USE AND DISCLOSE MEDICAL INFORMATION**

**ABOUT YOU IN SEVERAL CIRCUMSTANCES**

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at (361) 572-9654.

**1. Treatment**

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

**2. Payment**

We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

**3. Healthcare Operations**

We may use and disclose medical information about you in performing a variety of business activities that we call “healthcare operations.” These “healthcare operations” activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

* Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
* Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
* Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
* Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
* Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
* Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
* Planning for our organization’s future operations.
* Resolving grievances within our organization.
* Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
* Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

**4. Persons Involved in Your Care**

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors’ information, contact our Privacy Officer at (361) 572-9654.

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

**5. Required by Law**

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

**6. National Priority Uses and Disclosures**

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as “national priorities.” In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual’s permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the “national priority” activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at (361) 572-9654.

* **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
* **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
* **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
* **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
* **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
* **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
* **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
* **Workers’ compensation:** We may disclose medical information about you in order to comply with workers’ compensation laws.
* **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
* **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans’ activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

**7. Authorizations**

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the “authorization” – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

* Uses and disclosures for marketing purposes.
* Uses and disclosures that constitute the sales of medical information about you.
* Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
* Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at (361) 572-9654.

**1. Right to a Copy of This Notice**

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at (361) 572-9654.

**2. Right of Access to Inspect and Copy**

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an **Access Request Form**. Access Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

**3. Right to Have Medical Information Amended**

You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

**4. Right to an Accounting of Disclosures We Have Made**

You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

**5. Right to Request Restrictions on Uses and Disclosures**

You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

**6. Right to Request an Alternative Method of Contact**

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

**7. Right to Notification if a Breach of Your Medical Information Occurs**

You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

* A brief description of what happened;
* A description of the health information that was involved;
* Recommended steps you can take to protect yourself from harm;
* What steps we are taking in response to the breach; and,
* Contact procedures so you can obtain further information.

**8. Right to Opt-Out of Fundraising Communications**

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

**We will not take any action against you or change our treatment of you in any way if you file a complaint.**

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

**Attention: Privacy Officer**

 **Premier Sleep Disorders Center**

 ***111 Northpark Drive***

 ***Victoria, Texas 77901***

 ***Phone: (361) 572-9654 Fax: (361) 485-2233***

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs.gov

**PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION SHEET**

**Premier Sleep Disorders Center**

111 Northpark Drive, Victoria, Tx. 77901● (361)572-9654 Fax: (361) 485-2233

www.premiersleep.com

**PATIENT INFORMATION: DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

GENDER: \_\_\_\_\_MALE \_\_\_\_\_FEMALE EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COMPLETE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF A MINOR (PARENT’S NAME):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MARITAL STATUS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBERS (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Work):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DRIVER’S LICENSE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

EMPLOYER TELEPHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE COMPLETE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DRIVER’S LICENCE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSES’ EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION:**

ARE YOU COVERED BY INSURANCE? \_\_\_\_\_YES \_\_\_\_\_NO

MEDICARE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAID NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PRIMARY INSURANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

INSURED’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OFSECONDARY INSUSRANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

INSURED’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POLICY #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE# :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME TELEPHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK TELEPHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_

**Confidentiality is of the utmost importance. Therefore, it is necessary that we obtain your permission to notify you by phone or mail. Please provide phone numbers and/or addresses where you may be contacted.**

**Home: \_\_\_\_\_ (Y/N), phone/address listed above or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work: \_\_\_\_\_ (Y/N), phone/address listed above or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Information may be discussed with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we leave information on an answering machine? \_\_\_\_\_ (Y/N) Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we email you? \_\_\_\_\_\_\_\_\_ (Y/N) May we text you? \_\_\_\_\_\_\_\_\_\_\_ (Y/N) ##\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification requirements for any and all plans to which I subscribe may cause me to incur full liability for charges as a result of non-payment by my carrier.**

**Please remember that insurance is considered a method of reimbursing the patient and/or provider for fees and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCES NOT PAID BY YOUR INSURANCE.**

 **Premier Sleep Disorders Center**

 **Sleep sound • Sleep safe • Sleep well l**

**111 North Park Drive**

 **Victoria, Texas 77901**

 **Phone: (361) 572-9654 Fax: (361) 485-2233**

POLYSOMNOGRAM QUESTIONNAIRE

ASSESSMENT OF YOUR SLEEP AND WAKEFULLNESS

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sleep Page 1**

**MAIN SLEEP COMPLAINT** (briefly describe your sleep complaint). Describe when/how it began. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIOR SLEEP DISORDERS DIAGNOSIS OR STUDIES**? **YES**  **NO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am currently prescribed CPAP / BiPAP/ Auto PAP/ ASV: (Settings)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I use oxygen during the day/ night \_\_\_\_\_\_\_ liters per minute.

I have had surgery fore sleep disorders (UPPP / Tonsillectomy).\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I use a dental device for sleep disordered breathing.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much of these beverages do you consume**? Place 0 in blank if none.

Coffee \_\_\_\_cups/day \_\_\_\_cups after 6 pm

decaf coffee \_\_\_\_cups/day \_\_\_\_cups after 6 pm

tea(hot or cold) \_\_\_\_glasses/day \_\_\_\_glasses after 6 pm

carbonated drinks \_\_\_\_cans/bottles/day \_\_\_\_cans/bottles/after 6 pm

beer,wine,liquor (circle one) \_\_\_\_drinks before 6 pm drinks after 6 pm\_\_\_\_of alcohol

**SLEEP PATTERN**

Usual bedtime on workdays\_\_\_\_\_\_\_\_am/pm; days off\_\_\_\_\_\_\_\_\_am/pm

How long does it take to go to sleep on workdays\_\_\_\_\_\_minutes; days off\_\_\_\_\_\_minutes

Usual time to get up on workdays\_\_\_\_\_am/pm; days off\_\_\_\_\_\_am/pm

How much sleep do you feel you get each night?\_\_\_\_\_\_\_hours

Number of awakenings per night\_\_\_\_\_\_. Number of bathroom trips per night\_\_\_\_\_\_\_\_.

How long does it take you to “get going” in the morning (become fully alert and functional)? \_\_\_\_\_\_\_hours;\_\_\_\_\_\_minutes

**INSTRUCTIONS:** Circle **YES** or **NO** or fill in blanks as indicated. Circle **NO** if the problem is very infrequent. Place an X beside any question you do not understand or cannot answer by a simple **YES** or **NO.**

**SLEEP ENVIRONMENT HABITS**

Typical sleep position(s) □ back □side □stomach □head elevated □ in a chair □ sleep alone

**Yes No** I have pets in the bedroom.

**Yes No** I watch TV in the bed prior to sleep.

**Yes No** I read in bed prior to sleep.

**Yes No** I work or study in bed.

**Yes No** I drink alcohol prior to bedtime.

**Yes No** I smoke prior to bedtime or when I awaken during the night.

**Yes No** I eat a snack at bedtime.

**Yes No** I eat if I awaken during the night.

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sleep Page 2**

**BREATHING**

**Yes No** I have been told I snore loudly.

**Yes No** I have been told that I stop breathing while asleep.

**Yes No** I have been told that I snore only when sleeping on my back.

**Yes No** I have been awakened by my own snoring.

**Yes No** I awaken at night choking or gasping for air.

**Yes No** I awaken short of breath.

**Yes No** I have trouble breathing when flat on my back.

**Yes No** I have trouble breathing through my nose.

**Yes No** I have morning headaches.

**Yes No** I sweat a great deal at night.

**DAYTIME SLEEPINESS**

**Yes No** I often feel drowsy during the day, more than I expect is normal.

**Yes No** I feel unrefreshed or tired in the morning despite sleeping at night.

**Yes No** I take daytime naps. How many ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** I have uncontrollable urges to fall asleep during the day.

**Yes No** I have experienced lapses in time or blackouts.

**Yes No** I have fallen asleep while driving.

**Yes No** I performed poorly in school or work because of sleepiness.

How likely are you to doze off or fall to sleep in the following situations, in contrast to just feeling tired? Even if you haven’t done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing

2 = moderate chance of dozing 3 = high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation Chance of dozing (0-3)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting and reading 0 1 2 3

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Watching television 0 1 2 3

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting inactive in a public place- for example, a theater or 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 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:

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sleep Page 3**

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, base on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

* A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
* It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that: Disagree Agree

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. My motivation is lower when I am fatigued. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Exercise brings on my fatigue. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. I am easily fatigued. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Fatigue interferes with my physical functioning. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Fatigue causes frequent problems for me. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. My fatigue prevents sustained physical functioning. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Fatigue interferes with carrying out certain duties

 and responsibilities 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Fatigue is among my three most disabling symptoms. 1 2 3 4 5 6 7

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Fatigue interferes with my work, family, or social life. 1 2 3 4 5 6 7

 Total Score:

**RLS**

**Yes No** I kick or jerk my legs excessively during sleep. □ This bothers my bed partner.

**Yes No** I experience a creeping-crawling or tingling sensation in my legs when I try to

 fall asleep.

**Yes No** I experience an inability to keep my legs still prior to falling asleep.

**Yes No** I experience the feeling of restlessness in my legs at night.

**OREXIN RELATED**

**Yes No** I experience sudden muscle weakness in response to emotions such as

 laughter, anger or surprise.

**Yes No** I experience an inability to move while falling asleep or when waking up.

**Yes No** I have experienced hallucinations or dreamlike images when falling asleep or

 Waking up.

**Yes No** I frequently dream during daytime naps.

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sleep Page 4**

**PARASOMNIAS**

**Yes No** I act on my dreams while asleep.

**Yes No** I have frequent nightmares.

**Yes No** I talk in my sleep.

**Yes No** I have sleep walked as an adult.

**MISCELLANEOUS (**Circadian, GERD, Depression, Enuresis, Bruxism, Pain)

**Yes No** I frequently travel across two or more time zones.

**Yes No** I am more alert in the morning than in the evening.

**Yes No** I awaken alert in the morning earlier than it is time to get up.

**Yes No** I frequently have heartburn or acid reflux at night.

**Yes No** Chronic pain interferes with my sleep.

**Yes No** The need to urinate frequently interrupts my sleep.

**Yes No** I grind my teeth in my sleep.

**Yes No** I have bedwetting (enuresis).

**INSOMNIA**

**Yes No** I have trouble falling asleep.

**Yes No** thoughts start racing through my mind when I try to fall asleep.

**Yes No** I have trouble remaining asleep.

**Yes No** I awaken frequently during the night.

**Yes No** I have difficulty returning to sleep if I awaken during the night.

**SOCIAL HISTORY**

Marital status □ Single □ Married □ Divorced □ Widowed

Employment status □ Employed Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** I regularly work night shifts.

**Yes No** I work rotating shifts, including nice shiftwork.

**FAMILY HISTORY**

Have an immediate blood relative had any of the following?

□ Obstructive sleep apnea □ Narcolepsy □ Other sleep disorders? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that all information is correct and complete to the best of my knowledge.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Premier Sleep Disorders Center**

 **Sleep sound • Sleep safe • Sleep well l**

**111 North Park Drive**

 **Victoria, Texas 77901**

 **Phone: (361) 572-9654 Fax: (361) 485-2233**

**PAST MEDICAL HISTORY**

NAME;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: M F DATE:\_\_\_\_\_\_\_\_\_\_

CURRENT WEIGHT:\_\_\_\_\_\_\_\_\_\_\_lbs. CURRENT HEIGHT :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WEIGHT 5YS. AGO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2YS AGO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6 mo. AGO:\_\_\_\_\_\_\_\_\_\_\_\_

ORDERING PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT PROBLEM (*DESCRIBE BRIEFLY)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS (*INCLUDE OVER THE COUNTER DRUGS)***

MEDS: HOW OFTEN TAKEN

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST PAST HOSPITALIZATIONS AND REASONS FOR HOSPITAL ADMISSION:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LIST PAST SURGERY DATES AND TYPES OF SURGERY:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EVER BEEN TREATED OR SUFFER FROM THE FOLLOWING: (*PLEASE CIRCLE)***

1. High Blood Pressure/ Hypertension 13. Rheumatic Fever
2. Atrial Fibrillation or Other Arrhythmia 14. Kidney Disease
3. Congestive Heart Failure or Cardiomyopathy 15. Epilepsy/Seizure Disorder
4. Coronary artery disease or atherosclerosis 16. Insomnia
5. Stroke or TIA (“mini-stroke”) 17. Narcolepsy
6. Diabetes 18. Sleep Apnea
7. Lupus 19. Thyroid Disease
8. Migraine, Headaches 18. Brain Tumor
9. Ulcers/Gastritis 19. Fibromyalgia
10. Gastro-esophageal reflux 20. Rheumatoid Arthritis
11. Depression / Anxiety 21. Angina
12. Emphysema / Asthma 22. Cancer ( Type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Describe any past or present Tobacco use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Describe any past or present Alcohol use: \_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**