THIS PAGE MUST BE COMPLETED

INSURANCE FORM

(INCLUDE COPY OF PATIENT'S INSURANCE CARD.)

Patient Name:_____ Gender: M☐ F☐

Address:_____

City:_____ State:_____Zip Code: _____
Phone:_____Other Phone: _____

DOB: _____Social Security Number: _____

Employer Name: _____Employer Phone:_____

Emergency Contact: _____ Phone: _____
Primary Insurance: _____ (Policy) ID #:_____
Name of Subscriber (If other than patient): _____
[If different than Patient: **SSN and DOB**:_____
Insurance Phone Number: _____Group #: _____

Secondary Insurance: _____ (Policy) ID #: _____
Name of Subscriber (If other than patient): _____
Insurance Phone Number: _____Group #: _____

Referring Physician:_____

OFFICE USE ONLY

Date of Study: _____

What Study Was Performed:

- ☐ 95782 PSG PED 5 and under
- ☐ 95783 CPAP PED 5 and under
- ☐ 95810 PSG
- ☐ 95811 SPLIT
- ☐ 95811 CPAP
- ☐ 95805 MSLT/MWT
- ☐ 95806 Home Testing Device

Suspected Disorder:_____ Amount Collected: _____ Bill Patient: _____
CASH_____**CHECK**_____ **CC**_____

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PRE-TEST QUESTIONNAIRE

Date _____

Name_____**D.O.B.** _____**Age** _____

☐ **Male** ☐ **Female** **Height** _____ **Weight** _____

Section I

Medical History:

- ☐ **High Blood Pressure**
- ☐ **Congestive Heart Failure**
- ☐ **Hiatal Hernia/Reflux**
- ☐ **Heart Attack**
- ☐ **Diabetes**
- ☐ **Stroke**
- ☐ **Bypass Surgery**
- ☐ **Asthma**
- ☐ **COPD**
- ☐ **HIV/AIDS**
- ☐ **Hepatitis Type**_____
- ☐ **Allergies** _____
- ☐ **Other**_____

Medications (herbal, patches, pumps, eye drops, OTC, and samples etc):_____

_____

_____

_____

_____

_____

_____

_____

Sleep studies typically end at 5:00 am however, if there is a chance your study ends early would you like to be able to leave at that time?

Yes☐ / No☐

THIS PAGE MUST BE COMPLETED

Name: _____Date: _____

Signs and Symptoms

Please check all of the following signs and symptoms which apply to you

_____Heavy snoring

_____Snoring interrupted by Silence and then gasping

_____Forgetfulness

_____ Anxiety/Depression

_____ Restless Sleep

_____Trouble Concentrating

_____ Loss of Libido

_____Short Temper

_____Irritability

_____Loss of Energy

_____ Fatigue

_____Morning Headaches

_____ Falling asleep at inappropriate times

Epworth Sleepiness Scale

How likely are you to doze-off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.
(use the following scale to select 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

Situation	**Chance of dozing**
Sitting and reading	_____
Watching T.V.	_____
Sitting, inactive in a public place (theatre or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	Total _____

Patient's Bill of Rights

Dr. Zzz's Sleep Center shall ensure that the patient is informed of their rights and that the staff of this facility will endeavor to perform their duties in a manner to ensure that all patients maintain these rights. The medical staff and employees of this facility shall encourage and assist the patient to exercise these rights. Any guardian or agent of the patient may seek enforcement of these patient rights on behalf of the patient to the extent of the law.

1. **The patient has the right to considerate and respectful care given by competent personnel.**
2. **A patient has the right, upon request, to be given the name and functions of other persons having direct contact with the patient.**
3. **A patient has the right to consideration of privacy concerning his/her own healthcare program. Case discussion, consultation, and examination are considered confidential and shall be conducted discreetly.**
4. **A patient has the right to have records pertaining to his/her care treated as confidential except as otherwise provided by law.**
5. **The patient has the right to expect emergency procedures to be implemented without unnecessary delays.**
6. **The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications.**
7. **A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when the practitioner is considering the patient as part of a medical care research program or donor program, and the patient or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given informed consent.**
8. **A patient has the right to refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.**
9. **A patient has the right to services without discrimination based on age, race, color, religion, national origin, handicap, disability or source of payment.**
10. **The patient who does not speak English, or has other disabilities concerning hearing or speech, shall have access, where possible, to an interpreter.**
11. **Dr. Zzz's Sleep Center shall provide the patient, or patient designee, upon written request, access to the information contained in his/her medical record and according to Federal and State HIPAA regulations.**
12. **The patient has the right to receive a detailed explanation of his/her bill.**
13. **A patient has the right to have and advanced directive (such as a living will, healthcare proxy, or durable power of attorney for healthcare) concerning treatment or designating a surrogate decision maker with the intent of that directive to the extent permitted by law. However, due to the nature of care provided at Dr. Zzz's Sleep Center, advanced directives cannot be honored. If a copy of the advanced directive is available at the facility and the patient's health status requires transfer to a hospital a copy of the advanced directive will be sent with the patient.**
14. **Any questions and/or complaints can be directed to Philip Zoellner Dr. Zzz's Sleep Center's COO (918-728-7552) and/or The Joint Commission 630-792-5000 www.jointcommission.org or**
    The Joint Commission
    One Renaissance Boulevard
    Oakbrook Terrace, IL, 60181

Patient's Signature **Date**

Release and Consent Form

1. I hereby authorize my health care provider, Dr. Zzz's Sleep Center, hereinafter "Provider," to furnish to my insurance company, or other person or entity involved in my treatment with a full report of my case history, examination, diagnosis, treatment, prognosis, or other medical/billing information in regard to my treatment by Provider.
2. I hereby give my consent for video monitoring and recording for the professional use in diagnosing and recommending treatment.
3. Some insurance companies, including Blue Cross Blue Shield send payment directly to the patient for the sleep study. This money is the insurance company's portion for the sleep study. This is not reimbursement for any out-of-pocket expenses you might have paid. These checks must be forwarded over to Dr. Zzz's Sleep Center within 10 days of receiving. These checks are often adjoined to the patients' EOB (Explanation of Benefits).
4. If for any reason you are unable to make your appointment, you must notify our office within 48 hours of your scheduled appointment. Failing to cancel or reschedule in a timely fashion will mean you will be expected to pay $150 fee. This fee is simply to offset the expense of the sleep technician who is limited to only two (2) patients per night and the sleep center, which by design can only schedule a maximum of four (4) patients per night. Any cancellation fees collected would be in addition to any fees that you might be required to pay.
5. I am aware that I may choose a provider for durable medical equipment as provided by the law. DME equipment related to a sleep treatment can include but not limited to CPAP/Bi-Level machines, masks hoses, and possibly oxygen supplies. Should the need for DME equipment arise, please check below the course of the action you wish Dr. Zzz's Sleep Center to provide.

_____ I accept the DME provider chosen by
Bristow Medical Sleep Center
_____ I choose to use my own provider

Name of provider:_____
Contact name: _____
Phone: _____

Patient's Signature **Date**

Interpreting Physician Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to the interpreting physician. I acknowledge that I am responsible for my co-payment or unmet deductible amounts required by my insurance company and rejections. The interpretation fee is separate from the actual sleep study monitoring fee.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including collection agency fees.

I hereby authorize the interpreting physician to furnish to my insurance company or its agent(s) any information concerning my medical history, services rendered or treatment needed to process claims.

Technical Component Assignment of Benefits

I understand the same agreement shall apply to billing of the technical aspect of my sleep study. A technical fee is separate from the actual interpretation fee. These fees are negotiated by your insurance carrier and labeled "allowable amount". I authorize Bristow medical Center to bill for the technical component of my sleep study.

Efforts to pre-certify the procedure with my insurance company have been made. My out of pocket for the sleep study has been discussed with me prior to my sleep study and payment and billing arrangements have been made.

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

Patient Signature Date

patient unless the account for this hospital, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account for this hospitalization is paid in full. I understand that I am responsible for any charges not covered by my insurance company. The undersigned individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the Hospital.

If the patient fails to make payment when due and the account becomes delinquent or is turned over to a collections agency or an attorney for collection, the undersigned shall pay all collection agency fees, court costs and attorneys' fees. The undersigned agrees that the patient or guarantor overpayments on the above hospital stay/visit may be applied directly to any delinquent account for which the patient or guarantor is legally responsible at the time of the collections of the overpayment.

7) WEAPONS/EXPLOSIVES/DRUGS: I understand and agree that if the Hospital at any time believes there may be a weapon, explosive device, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Hospital may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate including delivery of any item to law enforcement authorities.

8) PRIVATE ROOM DIFFERENCE: I agree and understand that if I request a private room for the patient, I am responsible for the entire private room difference. _____Initials

9) ADVANCED DIRECTIVE ACKNOWLEDGMENT: Federal law requires that you be provided information about your right to make advanced health care decisions, including a Living Will, Durable Medical Power of Attorney or designation of a surrogate decision maker for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Hospital.

10) Patient Rights and Responsibilities: I agree that I have received a statement of patient rights and responsibilities.

PLEASE INITIAL THE FOLLOWING APPLICAPLE STATEMENTS:

_____I have executed an advanced directive and have been requested to supply a copy to the Hospital.

_____I have reviewed the directive(s) on file with this facility and it is/they are my current directives(s).

_____I have not executed any advanced directives.

_____I have received information about advanced directives from the Hospital.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

X _____ X _____

Signature of Patient or their legal representative | Date/Time signed

X _____ X _____

Relationship to Patient | Witness

CONDITIONS OF ADMISSION – BRISTOW MEDICAL CENTER

1) GENERAL CONSENT FOR TEST, TREATMENT, SERVICES: I hereby voluntarily consent, for admission/treatment to the Hospital. I permit the Hospital and its employees, my physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests. I consent to examinations, blood tests, including blood tests for communicable diseases such as hepatitis and HIV/AIDS (including testing where healthcare personnel have been exposed to my blood and/or body fluids). Laboratory procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Hospital personnel under the instructions, orders or direction of such physician(s).

INDEPENDENT STATUS OF PHYSICIANS, RESIDENTS, MEDICAL STUDENTS AND NURSES – CAUTION! PLEASE READ CAREFULLY BEFORE SIGNING:

The medical treatment rendered during my hospital admission may be provided by physicians, residents, and medical students (under the supervision of physicians and/or residents). These physicians, residents, and medical students are independent contractors and not employees of the hospital. By signing this document, I hereby acknowledge that I have received adequate notification of this relationship and that the hospital is released from liability and is not legally responsible for the acts or omissions of such individuals.

In addition, nursing care rendered during my hospital admission may be provided by nurses or other professional staff who are also independent contractors or employees of a placement agency and not employees of the hospital. By signing this document, I hereby acknowledge that I have received adequate notification of this relationship and that the hospital is released from liability and is not legally responsible for the acts or omissions of such individuals.

Further, by signing this document, I hereby acknowledge that the hospital has not represented or taken any other action to induce me to believe that the physicians, residents, medical students and nurses are employees or agents of the hospital.

2) GENERAL DUTY NURSING: The Hospital provides only general duty nursing care. Private duty nursing is not provided buy may be arranged directly between an agency and the patient at the patient's expense. The Hospital is hereby released from any and all liability arising from the fact that I am not provided private duty care by the Hospital.

3) PERSONAL VALUEABLES: I understand that the Hospital maintains a safe for the safekeeping of money, valuables and personal belongings, and the Hospital shall not be liable for the loss or damage to any articles of personal property while I am hospitalized unless said articles are deposited with the Hospital in the safe and receipts are issued describing said items. At no time shall Hospital be responsible for more than $500 for said deposited items.

4) MEDICAL DEVICES: I agree to the release of my social security number and other required information to the manufacturer and the Food and Drug Administration of medical devices I may receive in accordance with federal laws and regulations. I understand that this information may be used to locate me should there be a need with regard to such medical device(s).

5) AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize Hospital and all physicians involved in my care to disclose ar release medical record information including my diagnoses (which includes but is not limited to alcohol or drug abuse, psychiatr cell anemia, HIV test results and AIDS/acquired immunodeficiency syndrome). Operative and other procedures and treatments, like relating to my medical history and hospital admission to any organization which is or may be liable or responsible for payme hospital and physician charges, including, but not limited to, the Social Security Administration and its intermediaries, Medicare Medicaid and insurance companies, and to physicians and agencies performing review functions authorized by contract, law or regulation. I also authorize the Hospital and all of my physicians to disclose my medical information to any home health agency, equipment agency, or other facility or agency which is involved with my discharge planning and my care after transfer or discha the Hospital. I also authorize release to ambulance and other medical transport companies and medical equipment representat have been or will be involved with my care. I understand that state law requires the Hospital to report certain positive test resu as hepatitis and the antibody for HIV/AIDS virus to the Health Department. My medical information described above and appro records as permitted by law may be disclosed and released to any such persons or organizations upon their request both durin my hospital stay. I understand and agree that federal and state entities, including but not limited to, the Center for Medicare Si the state department of health and the Joint Commission on the Accreditation of Healthcare Organizations, may have access to medical records. I discharge and release Hospital and its employees from any responsibility and liability arising out of the disclo use of such information by such persons and organizations. I also authorize the release of my medical information to the physi listed as my personal or family physician(s) upon registration and to any referral physicians.

6) ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY: I hereby assign and authorize payment directly to Hospital, and to any hospital-based physicians, all hospital benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, etcetera to or for the

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. **If you have other questions on this notice or Medicare billing, call** 1-800-MEDICARE **(1-800-633-4227**/TTY: **1-877-486-2048).** Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

BRISTOW MEDICAL CENTER
700 W 7TH AVE, SUITE 6
BRISTOW, OK 74010
918-367-2215 PHONE 918-367-4481 FAX

PATIENT'S NAME_____ACCOUNT#_____

ESTIMATED BALANCE DUE: $_____PAID AT TIME OF SERVICE: $_____

MONTHLY PAYMENT AMOUNT: $_____MONTHLY PAYMENT DUE DATES: _____

TERMS OF CONTRACT

- ALL PAYMENTS ARE DUE ON OR BEFORE MONTHLY DUE DATE.
- THIS PAYMENT PLAN AGREEMENT WILL REMAIN IN EFFECT AS LONG AS THE AGREED PAYMENT SCHEDULE IS MET.
- DEFAULT OF ANY OF THE TERMS OF THIS PAYMENT SCHEDULE, THE ORIGINAL BALANCE MINUS ANY PAYMENTS SHALL BECOME DUE IMMEDIATELY.
- FAILURE TO SIGN AND RETURN THIS DOCUMENT DOES NOT RELIEVE THE PATIENT'S OBLIGATION TO THIS AGREEMENT OF THE BALANCE ON THE ACCOUNT.
- BRISTOW MEDICAL CENTER RESERVES THE RIGHT TO RENEGOTIATE THE MONTHLY PAYMENT AMOUNT AT ANY TIME.

_____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE

_____

PRINTED NAME OF PATIENT/RESPONSIBLE PARTY DATE

_____

AUTHORIZED REPRESENTATIVE DATE

PLEASE REMIT ALL PAYMENTS TO: