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EASTAR HEALTH SYSTEM

DR. ZZZ'S GROUP, INC SLEEP CENTER
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 under 5
- ☐ 95783 CPAP PED under 5
- ☐ 95810 PSG
- ☐ 95811 SPLIT
- ☐ 95811 CPAP
- ☐ 95805 MSLT/MWT
- ☐ 95806 Home Testing Device

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

EASTAR HEALTH SYSTEM

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 _____

Release and Consent Form

1. I hereby authorize my health care provider, Eastar Health System 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 Eastar Health System 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 Eastar Health System Sleep Center to provide.

_____ I accept the DME provider chosen by
Eastar Health System 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 Eastar Health System Sleep 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

Conditions of Admission & Authorization for Medical Treatment

1. Consent to Treatment. I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I consent to have my blood tested for blood borne pathogens, including HIV, if there is an exposure of my body fluids to another person while I am at the hospital. I will have information about HIV made available to me should an exposure occur. I understand that as part of their training, students in health care education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that these students will be supervised by instructors and hospital staff.

2. Financial Agreement. In consideration of the services to be rendered to the patient, I individually promise to pay the patient's account at the rates stated in the hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. You may request information about these programs from the hospital.

As a courtesy to you, the hospital may bill your insurance company, but is not obligated to do so. Regardless, you agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You agree to pay any services that are not covered by your insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or

policy exclusions as well as failure to comply with your insurance plan requirements. You also agree that if the hospital must initiate collection efforts to recover amounts owed by you, then in addition to amounts incurred for the services rendered you will pay: (a) any and all costs incurred by the hospital in pursuing collection, including, but

not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the hospital that applicable rules or statutes permit the hospital to recover.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policy are not relieved of their obligation to pay for these services.

3. Release of Information. I permit the hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information necessary for treatment, payment or healthcare operations in accordance with state and federal law. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. This consent specifically includes information concerning psychological conditions, psychiatric conditions, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

4. Assignment of Benefits. In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the hospital and/or hospital-based physicians directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians, I hereby irrevocably assign and transfer to the hospital and/or hospital-based physicians all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. This assignment shall be for the purpose of granting the hospital and/or hospital based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the hospital and/or hospital based physicians to pursue any such right of recovery. In no event will

the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital based physicians in collecting payment from any such third party payer. I hereby appoint the hospital as my authorized representative to pursue, if it so chooses, all administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charges, plus expenses and attorney's fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital based physicians.

**Hospital-based physicians include but are not limited to: Emergency Department Physicians, Hospitalists, Pathologists, Radiologists, and Anesthesiologist, Psychiatrists, Psychologists or other Behavioral Health Providers. These services are rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.*

5. Private Room. I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and use of a private room.

6. Communications About My Healthcare. I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others responsible for my care or designated by me. I will provide those individuals with a password or other verification means specified by the hospital.

7. Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

8. Other Acknowledgements

a. **Legal Relationship Between Hospital and Physicians. Many of the health care professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors**. I understand that many of these independent practitioners or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

b. **Personal Valuables**. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient.

c. **Weapons/Explosives/Drugs**. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

d. **Additional Provision for Admission of Minors.** I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient**.**

9. Patient Rights & Patient Self Determination Act.

I have been furnished with written information regarding patient rights and responsibilities and other information related to my stay. I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). Please initial or place a mark next to **one** of the following applicable statements.

	I executed an Advance Directive and have been requested to supply a copy to the hospital		I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive		I have not executed an Advance Directive and do not wish to execute one at this time

10. Notice of Privacy Practices. I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ (Initial)

Date:	**I**, the undersigned, as the patient or legal agent of the patient, hereby certify I have read fully and completely understand this Conditions of Admission and Authorization for Medical treatment and that I have signed this Conditions of Admission and Authorization for Medical treatment knowingly, Freely, voluntarily and agree to bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services
Time:	

Patient/Authorized Representative Signature:	**Witness Signature and Title:**
X _____	**X**_____
If you are not the patient, please identify your Relationship to the patient. **(Circle or mark relationship(s) from list below**): Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Other (please specify*):*_____	**Additional Witness Signature and Title:** (required for patients unable to sign without a representative or patients who refuse to sign) **X**_____

Conditions of Admission