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AFFILATED WITH

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): _____

SSN and DOB (if different from patient): _____

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** _____

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 (including herbal, patches, pumps, eye drops, OTC, and samples etc.):

_____

_____

_____

_____

_____

_____

_____

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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 TV	_____
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 are limited to only two (2) patients per night and the sleep center, which by design can only schedule a maximum of five (5) patients per night. Any cancellation fees collected would be in addition to any fees that you might be required to pay.
5. Insurance guidelines regarding Obstructive Sleep Apnea and sleep studies are very stringent. If you do not meet criteria for both diagnostic and treatment during your initial sleep study, you may be required to return in-lab for a non-consecutive second night titration study. This is billed as a separate study, and any applicable co-pays and/or coinsurances will be the responsibility of the patient. You will be notified if this applies to your individual situation.
6. I am aware that I may choose a provider for Durable Medical Equipment (DME) 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 Dr. Zzz's Sleep Center

_____ I choose to use my own provider

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

Patient's Signature **Date**

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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. The interpretation fee is separate from the actual sleep study monitoring fee, and Dr. Zzz's Sleep Center is unable to provide specific information regarding this charge. For an estimated out-of-pocket amount, contact your insurance company regarding coverage of the 26 modifier or component for a professional interpretation fee of a sleep study.

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 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 Dr. Zzz's Sleep Center to bill for the technical component of my sleep study.

Insurance and Billing

I am aware that efforts to pre-certify the procedure with my insurance company have been made and my estimated out-of-pocket for the sleep study has been discussed with me prior to my sleep study. I agree payment and billing arrangements have been made and acknowledge that I am responsible for my co-payment, coinsurance and/or unmet deductible amounts required by my insurance company and rejections. 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.

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

Patient Signature Date