SLEEPWERX

YOUR SLEEP AND WELLNESS CENTER

SLEEP CONSULTATION CONSENT

I have been referred to SleepWerx, LLC for a sleep consultation. If it is determined that I require a sleep study, it will be scheduled accordingly.

I understand that my nurse practitioner will be asking me questions about my symptoms and will complete my consultation to determine which study (if any) would be best for me.

I UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND I AGREE TO PROCEED WITH THE SLEEP CONSULTATION.

Patient Name (printed): _____

Patient Signature: _____

If the patient is a dependent, please print the name of the patient's representative:

_____, Relationship to patient: _____

Representative Signature: _____

Date: _____

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Appointment Date: _____

Patient name: _____ DOB: _____

Patient S.S. #: _____ Gender: _____ Marital status: _____

Patient address: _____ # _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Primary Care Provider? _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone: _____

Insurance card presented today: Yes / No Scanned to record: Yes / No

If no insurance card today:

Primary Insurance:
Carrier: _____ Group #: _____ Plan ID: _____

Guarantor name (if not self): _____ Relationship: _____

Guarantor DOB: _____ Guarantor S.S. #:_____

Secondary Insurance:
Carrier: _____ Group #: _____ Plan ID: _____

Guarantor name (if not self): _____ Relationship: _____

Guarantor DOB: _____ Guarantor S.S. #:_____

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Sleep Apnea Screening

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? This refers to how you have been feeling lately. If you have not been in these situations lately, estimate how you feel it would affect you. Please use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION

Sitting and reading	
Watching TV	
Sitting inactive in a public place (in a theater 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 lunch without alcohol	
In a car while stopped for a few minutes in traffic	
Total score	

****Score greater than 10 indicates Excessive Daytime Sleepiness**

STOP BANG

S (snoring)	Do you snore loudly?	Yes ____ No ____
T (Tired)	Do you often feel tired, fatigued, or sleepy during the day?	Yes ____ No ____
O (Observed)	Has anyone observed you stop breathing during your sleep?	Yes ____ No ____
P (BP)	Do you have or are you being treated for high blood pressure?	Yes ____ No ____
B (BMI)	Is your Body Mass Index > 30 kg/M?	Yes ____ No ____
A (Age)	Are you over 50 years old?	Yes ____ No ____
N (Neck Circ)	Is your neck circumference > 40 cm (16”)	Yes ____ No ____
G (Gender)	Are you a Male	Yes ____ No ____

****Answering yes to three or more items indicates you are at high risk of OSA**

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New Patient Intake Forms

Name: _____ DOB: _____ Date: _____
Preferred Email: _____ (Please be aware that email is not secure).
Home Phone: _____ Ok to phone: Yes / No Ok to leave message: Yes / No
Cell Phone: _____ Ok to phone: Yes / No Ok to leave message: Yes / No
Other Phone: _____ Ok to phone: Yes / No Ok to leave message: Yes / No
Preferred Name: _____ Birth Gender: Male / Female

Have you had a sleep study before? Yes / No Where: _____When: _____

IF you use CPAP or Oxygen at home, what are the settings? _____
Who is your Durable Medical Equipment (DME) supplier? _____

What are your top 3 sleep complaints/problems?
1. _____
2. _____
3. _____
How long have you had sleep problems? _____
On a scale of 1-10 (with 10 being the worst), how do your sleep problems affect your day to day functioning? _____

Do you work different shifts? Yes / No What is your sleep schedule? _____
What time do you normally go to bed? _____
How many nights per week does your bedtime vary? _____
How long does it take you to fall asleep after lights out? _____
How many times do you typically wake up at night? _____
How many times are you up to urinate at night (nocturia)? _____

Are you able to get back to sleep after night time waking? _____

Are you dreaming? _____
Have you been told that you shout, or "act out" your dreams during sleep? _____

How many nights (if any) do you experience nightmares? Yes / No
Do you have history of sleep talking (somniloquy)? Yes / No
Do you have history of sleep walking (somnambulism)? Yes / No
Do you have times that you are awake, but you cannot move or speak? (sleep paralysis) Yes / No
Do you feel sudden weakness or feel yourself go limp with intense emotion (cataplexy)? Yes / No
Do you see things that should not be there when going to sleep (hypnagogic hallucinations)? Yes / No
Do you see things that should not be there when waking up (hypnopompic hallucinations)? Yes / No
Are you restless during sleep? Yes / No Do you have limb jerking during sleep? Yes / No
Do you have Restless Leg Syndrome? Yes / No Do you wake up feeling exhausted? Yes / No

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Name: _____ DOB: _____ Date: _____

Do you have heartburn or acid reflux during sleep? Yes / No
Do you wake frequently due to pain? Yes / No Where is your pain? _____
Do you have nasal and/or sinus congestion or post-nasal drip during sleep? Yes / No

Do you have any of the following symptoms at night? (check all that apply)

___ Palpitations	___ Nightmares	___ Teeth grinding	___ None
___ Dry Mouth	___ Choking or Gasping	___ Heartburn	
___ Sweating	___ Coughing	___ Reflux	
___ Need to urinate	___ Headache	___ Body Aches/Pain	
___ Panic attacks	___ Chest pain	___ Leg discomfort/cramping	
___ Shortness of breath	___ Racing heart	___ Nasal/Sinus Congestion	

What time do you wake up? _____ Do you have morning headache? Yes / No
Of 7 mornings, how many would you wake up feeling refreshed? _____
Can you remember the last time you had a good night's sleep? Yes / No When? _____
How long after waking until you feel tired? _____ Sleepy or fatigue? _____
If you nap during the day, how long do you sleep? _____
Do you feel refreshed after a nap? Yes / No

Have you fallen asleep driving in the past one year? Yes / No Have you ever fallen asleep driving? Yes / No
Have you had a vehicle crash due to sleepiness? Yes / No Were there any injuries to yourself or others? Yes / No
Have you fallen asleep at a red light or stop sign in the past one year? Yes / No
Have you fallen asleep in a conversation in the past one year? Yes / No

How is your energy level during the day? _____
Do you feel more irritable? Yes / No Do you feel more depressed? Yes / No
Are you more forgetful? Yes / No Do you have difficulty concentrating? Yes / No
Are you more anxious? Yes / No
Are your sleep problems affecting your work? Yes / No
Have you lost or gained weight over the past one year? Yes / No How much? _____ On purpose? Yes / No

Family History

Do any family members have a sleep disorder? Yes / No Who? _____ Which disorder? _____
Have any family members suffered heart disease or stroke? Yes / No Who? _____
Do any family members have Bipolar Disorder, schizophrenia, depression, anxiety? Yes / No Who? _____
Other family health issues?

_____

_____

_____

SleepWerx 3514 N. Power Rd., Suite 127. Phone: 480-571-8460 Fax: 480-571-8461

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Name: _____ DOB: _____ Date: _____

Social History

Married? Yes / No Spouse name? _____ Single? Yes / No Divorced? Yes / No
Do you use alcohol? Yes / No How often/week? _____ How many at once? _____
Do you use street drugs? Yes / No Marijuana? Yes / No Card? Yes / No Others? _____
Do you use tobacco? Yes / No How much/day? _____ How many years? _____ Quit when? _____
Are you working? Yes / No Where? _____ Type of work? _____
How long have you been at your current position? _____

Current list of medications: (Attach a list if necessary):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list any *medication allergies*: _____

Do you have allergies to: Tape: Yes / No Latex: Yes / No Other: _____

Past Medical History (please check all that apply):

___ None
___ CHF
___ Depression
___ Thyroid disorder
___ Head injury
___ Stroke
___ High cholesterol
___ Epilepsy
___ Hepatitis
___ Stomach ulcer
___ Diabetes
___ Sinus problems
___ Allergies
___ COPD
___ Heart attack
___ High blood pressure
___ Heart murmur
___ Kidney disease
___ Shortness of breath
___Pulmonary embolism
___ Pacemaker
___ Asthma
___ Heart arrhythmia
___ Chronic pain
___ Neuropathy
___ Heart surgery
___ Anemia
___ Kidney Stones
___ Substance abuse
___ DVT/blood clotting disorder

Please list any other significant medical history and or surgeries:

_____
_____
_____

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Name: _____ DOB: _____ Date: _____

Review of Systems:

CONSTITUTIONAL:
____ fatigue
____ weight changes
____ sleep disorders
____ weakness

HEENT:

Eyes:
____ blurred vision
____ double vision
____ runny eyes
____ eye pain

ENT:
____ earache
____ sore throat
____ runny nose
____ hearing loss
____ tinnitus.

CARDIOVASCULAR:
____ chest pressure
____ chest pain
____ chest tightness, heaviness or aching
____ palpitations
____ heart murmur

RESPIRATORY:
____ cough
____ shortness of breath
____ difficulty breathing at night or when lying flat

GASTROINTESTINAL:
____ nausea, vomiting
____ diarrhea
____ acid reflux
____ bowel incontinence

GENITOURINARY:
____ prostate disorder
____ urinary incontinence
____ urinary hesitation or urgency

HEMATOLOGICAL:
____ easy bruising, bleeding
____ anticoagulants
____ blood disorder

ENDOCRINE:
____ diabetes
____ thyroid disorder
____ hormone disorder
____ low testosterone

INFECTIOUS:
____ HIV/AIDS
____ hepatitis
____ tuberculosis
____ valley fever
____ bed bugs

MUSCULOSKELETAL:
____ joint pain
____ muscle pain
____ back pain
____ swelling in legs

SKIN:
____ change in skin, hair or nails
____ open lesions

NEUROLOGIC:
____ numbness
____ tingling
____ fasciculations
____ tremor
____ seizures
____ weakness
____ passing out (syncope)
____ dizziness
____ headaches
____ memory disorder

PSYCHIATRIC:
____ anxiety
____ insomnia
____ depression
____ bipolar disorder
____ schizo-affective disorder
____ schizophrenia
____ alcohol abuse
____ substance abuse
____ speech difficulties
____ ADHD

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Sleep Consult Cancellation Policy

Patients come first in our practice. In order to be respectful of other patients, please be courteous, and arrive on time and call promptly if you need to cancel. If you need to cancel your scheduled appointment, we require that you call at least 24-hours in advance, unless you have an emergency.

A “no-show” is someone who misses an appointment without notice or does not provide at least 24-hour notice of cancellation. Each no-show appointment you will be charged $50.00.

Please arrive at least 15 minutes prior to your appointment.

Thank you for your understanding and cooperation with the outlined policy.

Signature: _____ Date: _____

Staff Signature: _____

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SleepWerx, LLC Financial Policy

Welcome to SleepWerx! We strive for the excellent Provider-Patient relationship that you deserve. It is important that you understand our policies prior to your first visit. If this creates a flow of communication and leads to best possible care. If you have any questions, please take comfort in asking our staff for assistance. Your co-operation in following out payment policy is greatly appreciated.

1. Please arrive at least 15 minutes prior to your appointment, bringing your health insurance card and photo ID. It is your responsibility to provide correct insurance information. This is very important as incorrect insurance information will result in out of pocket expense to you as you are then responsible to pay the entire cost of the appointment. If you leave it will be considered a “no show” and a charge of $50.00 will be applied to your account.

2. Your insurance policy determines your responsibility in terms of co-payments, deductibles and coinsurances, not the Provider or the office. These payments are due at time of service. Please note: a “covered item or service” does not mean it is 100% covered. We will make every effort to explain, however it is your responsibility to understand your policy, required referrals and authorizations prior to your visit. Coverage, benefit and payment decisions do not constitute treatment decisions.

3. If you do not have insurance or SleepWerx is not contracted with your insurance company, payment for the visit is to be paid at the time of the visit (please see item 2). If we are “out of network” with your insurance plan, you will need to determine your out of network benefits. We will bill your insurance for the visit, but you will be financially responsible for the remainder of what is not covered by your out of network benefits.

4. As noted above, we require a 24-hour notice for a cancellation or re-schedule request. Failure to notify in this time frame will result in a $50.00 charge. Any fees applied to your account must be paid prior to your appointment. If 2 appointments are no showed, you will not be given a 3rd re-schedule.

5. If you are 15 minutes late, you might have to be re-scheduled depending on our volume that day. DO NOT EXPECT to just be next in, you will have to wait until the patients that arrived on time to finished. There is no need for them to suffer due to your latency.

6. We understand short term financial issues can arise which will affect your ability to keep your account current. We can, on our approval, allow 30 days to pay any outstanding balance on your account. If necessary, we can arrange monthly payments with an approved term.

PAYMENT METHODS: Money Order, Cash, Visa, Mastercard.

Signature: _____ Date: _____

Staff Signature: _____

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RECEIPT OF PRIVACY PRACTICE NOTICE

Signature on this document acknowledges receipt of the SleepWerx Notice of Privacy Practices. SleepWerx maintains strict compliance with the Health Information and Patient Portability (HIPPA) Act, and the guidelines set in the Act.

Should you have questions regarding the information provided in the SleepWerx Notice of Privacy Practices, please advise the Practice Manager.

I HAVE BEEN PROVIDED, READ, AND UNDERSTAND MY RIGHTS UNDER THE PATIENT PRIVACY PRACTICES.

Patient Name (printed): _____

Patient Signature: _____