PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name: Last _____ First _____ Middle_____

Address: _____ City _____ State _____ Zip _____

Phone: Home_____ Work _____ Cell _____

Date of Birth: _____ Sex: M / F

Drivers License # _____ Social Security # _____

Employer: _____ Job Title_____

Employer's Address: _____ City _____ State _____ Zip _____

Primary Care Physician: _____ PCP Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Plan Type: HMO / PPO

Policy/ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's SSN: _____ Relationship to patient: _____

Employer's Name: _____ Employer's Phone: _____

Secondary Insurance: _____ Plan Type: HMO / PPO

Policy/ ID Number: _____ Group Number: _____

Policy Holder's Name: _____ Relationship to patient: _____

Employer's Name: _____ Employer's Phone: _____

The above information is correct an up to date

Signature:_____ **Date:**_____

(Signature of Patient / Responsible Person)

Academy Diagnostics
Notice of Privacy Act

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accounting Act of 1996 (HIPAA)

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

Uses and Disclosures

Treatment. Your health information may be used by office staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Academy Diagnostics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluated and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization; but it will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have the right under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.

- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Academy Diagnostics' Office Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice of any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer, Academy Diagnostics, 8215 Fredericksburg Road, San Antonio, Texas 78229. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practice, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Academy Diagnostics
8215 Fredericksburg Road
San Antonio, TX 78229

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filling a complaint.

Effective Date

This notice is effective on or after June 1, 2007.

Date: _____ **Name:** _____

Academy Diagnostics is dedicated to providing you the best possible care and regards your understanding of our financial policy as an essential element of your care and treatment.
Please read and initial that you have read and understand the information below:

Academy Diagnostics Sleep Center performs diagnostic testing and charges a pre-determined fee for our services.

_____**There are <u>TWO fees</u> charged for each procedure. There is a technical fee charged by the facility for performing the procedure AND a professional fee charged by the physician for the interpretation of that procedure. The technical fee is collected at the time of service by the facility; the professional fee is charged by the interpreting physician at a later date.**

_____There may be instances when the interpreting physician is not a contracted provider with the patient's health insurance plan. Every effort will be made to notify the patient in advance; however it is ultimately the patient's responsibility to contact the health insurance provider to obtain information regarding benefits.

_____The patient or other responsible person is ultimately responsible for understanding his/her insurance benefits and for payment of the charges incurred at Academy Diagnostics. If the patient is a minor, the parent or legal guardian would be considered the person responsible for payment.

_____If Academy Diagnostics is a contracted provider with the patient's health insurance plan, we will accept assignment of benefits and bill the health plan on the patient's behalf. The patient will be responsible to pay any deductible and co-insurance at the time of the visit.

_____If Academy Diagnostics is not contracted with the patient's health insurance plan, we may, on a case-by-case basis, submit the claim to the health insurance plan on the patient's behalf. The patient will be responsible for the balance of charges not covered by the out-of-network benefits under the health insurance plan.

_____ If the patient elects a Private Pay Agreement option, Academy Diagnostics will not accept benefits and will not submit a claim to the health insurance plan for payment.

I, the undersigned, have read and understand the financial policy and realize that all charges incurred by me or my dependents for the ***separate technical and professional services*** rendered by <u>Academy Diagnostics</u> are my financial responsibility. I further agree to pay charges as outlined above or pay any and all court costs, attorneys' fees, or any other fees necessary to collect payment of the charges I incurred.

Signature:_____
(Signature of Patient / Responsible Person)

Date: _____ **Name:** _____

Please read and initial that you have read and understand the information below:

ASSIGNMENT OF BENEFITS

_____I certify that I or my dependent has active health insurance and assign directly to Academy Diagnostics and the interpreting physician all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Academy Diagnostics and the interpreting physician may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This assignment of benefits will end when my current treatment plan is completed or one year from the date signed below.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

_____ I have received a copy of this office's Notice of Privacy Practices.

CONSENT FOR POLYSOMNOGRAM/EEG

_____I understand that I will be undergoing a diagnostic procedure. Electrodes and other sensors will be attached to my body. During the procedure, I will be free to move, but will need to ask for assistance to be disconnected. I will be observed on closed circuit TV throughout the procedure. There are no significant risks to me from the procedure.

PERMISSION FOR AUDIO/VIDEO TO BE USED FOR EDUCATION

I understand that audio/video will be recorded during the procedure for diagnostic purposes or in the event of legal action. I understand that Academy Diagnostics may need to copy these materials in whole or part.

_____I authorize the collected audio/video to be used for educational purposes. Any use of the audio/video for education will not identify me by name

_____I DO NOT authorize the collected audio/video to be used for educational purposes.

ABANDONED PERSONAL ITEMS

_____Any personal items left at the lab are considered abandoned. Academy Diagnostics does not take responsibility to safeguard any abandoned personal items. All abandoned personal items will be disposed after 2 weeks from procedure date.

Signature:_____
(Signature of Patient / Responsible Person)

History & Physical Information

Date: _____ **Name:** _____

Sleep	☐ EDS	☐ Snoring	☐ Witnessed Apneas
	☐ Insomnia	☐ Nocturia	☐ Frequent Awakenings
Physical	☐ Obesity	☐ Enlarged Tonsils	☐ Reduced Mobility
	☐ Reduced Dexterity	☐ High Arched Palate	☐ Weight Loss/Gain
	☐ Chronic Pain	☐ Fibromyalgia	☐ GERD
	☐ Anxiety	☐ Depression	☐ Diabetes
Parasomnias	☐ PLMD	☐ Sleep Walking	☐ Sleep Talking
	☐ Night Terrors	☐ Nightmares	☐ RBD
Pulmonary	☐ COPD	☐ Asthma	☐ CSA
	☐ O2 use	☐ Tracheostomy	☐ OHS
Neuro	☐ Seizures	☐ Stroke	☐ ADHD
	☐ Spina Bifida	☐ ALS	☐ Migraines
Cardiac	☐ CHF	☐ AFib	☐ Heart Attack
	☐ Pacemaker	☐ HBP	☐ Arrhythmias
PAP	☐ CPAP use	☐ BIPAP use	☐ Could not tolerate PAP

Current PAP settings _____

Other Concerns _____

_____

Neck Circumference _____ **Height** _____ **Weight** _____

Food/Drug Allergies: _____

Medications: _____ _____

_____ _____

_____ _____

_____ _____

Patient /Parent 's Signature: _____

The Epworth Sleepiness Scale

Date: _____ **Name:** _____

How often do you 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 choose the **most appropriate number** for each situation.

0 = Never Would Doze Off
1 = Slight Chance of Dozing Off
2 = Moderate Chance of Dozing Off
3 = High Chance of Dozing Off

SITUATION	**CHANCE OF DOZING**
SITTING AND READING	_____
WATCHING TV	_____
SITTING IN A PUBLIC PLACE (e.g., THEATER, MEETING)	_____
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	_____
LYING DOWN TO REST IN THE AFTERNOON, IF CIRCUMSTANCES PERMITTED	_____
SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL	_____
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	_____
SITTING AND TALKING TO SOMEONE	_____

TOTAL: _____

Berlin Questionnaire

Date: _____ **Name:** _____

Circle the most appropriate answer as it pertains to your usual way of life in recent times:

1. Has anyone noticed that you quit breathing during your sleep?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

2. Do You Snore?
   - Yes
   - No
   - Don't know

If you do NOT snore, ***skip to question 6***

If you snore:

3. Your snoring is?
   - Slightly louder than breathing
   - As loud as talking
   - Louder than talking
   - Very loud. Can be heard in adjacent rooms

4. How often do you snore?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

5. Has your snoring ever bothered other people?
   - Yes
   - No

6. How often do you feel tired or fatigued after your sleep?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

7. During your wake time, do you feel tired, fatigued or not up to par?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - Yes
   - No

   If yes, how often does it occur?
   - Nearly every day
   - 3-4 times a week
   - 1-2 times a week
   - 1-2 times a month
   - Never or nearly never

9. Do you have high blood pressure?
   - Yes
   - No
   - Don't know

BMI _____