Pulmonology Group LLC

Pulmonology Group, LLC Sleep Lab

Patient Sleep Study Packet

Please complete and bring with you to your sleep study appointment

Patient name: _____

DOB: _____ Gender: Male ____ Female _____

Age: _____ Height: _____ Weight: _____

Emergency Contact: _____

Primary Care Physician: _____

Epworth Sleepiness Scale (0-3)

0 = would never feel sleepy
1 = slight chance of being sleepy
2 = moderate chance of being sleepy
3 = high chance of being sleepy

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting Inactive in a public place (meeting, theater)	_____
As a passenger in a car for an hour without a beak	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after eating lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____

Total Points: _____

Do you have a problem with severe sleepiness during the day? Yes___ No___
Do you have a problem snoring? Yes___ No___
Do you fall asleep without meaning to during the day? Yes___ No___
Have you ever had a near auto accident because of sleepiness Yes___ No___
Have you been told you stop breathing during sleep? Yes___ No___

Past Sleep Evaluation and Treatment

I have had a sleep study previously. Yes___ No_____
If yes, my last overnight study was: _____
Where was your last sleep study completed? _____
I currently use CPAP/BiPAP. Yes____ No_____

Mask Type: _____

I have had surgery for Apnea. Yes___ No____ When?: _____

Sleep Habits

What is your normal bed time? _____
What time to you get out of bed in the morning? _____
How many times are you getting out of bed at night? _____
How many times are you waking at night? _____
Do you have insomnia? ___Yes ___No
Do you have trouble staying asleep once you go you bed? ___Yes ___No
Do you take naps during the day? Yes___ No___ How long? _____
Does your occupation require that you change shifts? Yes____ No_____

How much of the following do you consume during the day?

Coffee:
_____

Tea:
_____

Cigarettes:
_____

Alcohol:
_____

Soft Drinks:
_____

Energy Drinks:
_____

Medical Marijuana:
_____

Medical History

Please check box if you have or have had any of the following conditions:

- ☐ Allergies
- ☐ Asthma
- ☐ Bladder problems
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Memory problems
- ☐ COPD
- ☐ Seizures
- ☐ Headaches
- ☐ Heart problems
- ☐ Panic attacks
- ☐ High Blood pressure
- ☐ Stroke/TIA
- ☐ Sexual disfunction
- ☐ Atrial Fibrillation
- ☐ GERD/Reflux
- ☐ Arrhythmias
- ☐ Insomnia
- ☐ Snoring
- ☐ Weight Changes
- ☐ Hepatitis
- ☐ PTSD
- ☐ CHF
- ☐ MRSA
- ☐ HIV/AIDS
- ☐ Coronary Artery Disease

Please List Medications you are taking below

Consents for Sleep Study

_____ initial
I, the undersigned, voluntarily request Pulmonology Group, LLC Sleep Lab, its physicians, associates, technicians, and other health care providers, as they may deem necessary, to treatment my condition. I understand that the following diagnostic and/or treatment procedures are planned for me, and I do voluntarily consent to and authorize these procedures and treatments.

_____ initial
In order to measure the various characteristics of my sleep, I understand that small metal button sensors will be pasted and/or taped to my scalp (no hair is removed from the scalp to apply these electrodes). Location of electrodes are approximately one-half inch away from my eyes and by my chin and in my hair to measure my brain waves and the quality of my sleep. Electrodes and other sensors will be attached to my body. In addition, small sensors will be taped to my chest to measure my heart rate. The same type of sensors will be placed on the legs to measure leg movements. The tape used may cause discomfort at removal or adhesive used may cause redness at the site of attachment. If redness or irritation occurs, an over the counter hydrocortisone cream may be used. If you have a known allergy to tape please notify the technician first.

_____ initial
A small wire and cannula will be placed under my nose to measure airflow from the nose and mouth.

_____initial
A sensor will be taped to the neck to monitor snoring

_____ initial
Elastic stretch bands will be placed around chest and abdomen to measure my breathing.

_____initial
An oxygen sensor will be placed on finger to measure bloody oxygen levels.

Consents for Sleep Study Continued

_____ initial
The entire sleep study will be monitored by a trained Polysomnography technologist. I understand that part of the study and safety monitoring involves a continuous audiovisual monitoring of me by a video camera and a sensitive microphone that detects my breathing noises and my speech. This recording may be reviewed by the sleep clinic physicians and technologist's performance. I also undertint that my sleep recording may be used for specific or educational purposes without my identity being revealed.

_____ initial
During the study I will be free to roll over in bed, but will have to ask assistance to get out of bed. I will be observed on a closed-circuit monitor throughout the study. Note an intercom is used for communications between the patient and technician. I have had the opportunity to ask questions and I consent to the sleep study.

Consent for Video Recording and Sleep Monitoring

_____ initial
I, hereby give my permission to the Pulmonology Group, LLC Sleep Lab to perform the sleep study, digital video recording by CCTV and deemed advisable for diagnostic treatment and/or educational purposes.

Authorization to Disclose HIPAA Protected Health Information

_____ initial
I authorize Pulmonology Group, LLC Sleep Lab, who will be processing the data from my sleep test report(s), to release the report(s) to the physician who ordered the test and to the DME provider who may be supplying the equipment.

Consents for Sleep Study Continued

Cancellation/No Show

____ initial

I understand I am responsible to provide **48 hours in advance of my sleep study** to cancel or change my appointment. I understand there is a voice mail where I can leave my message. I understand that failure to call in 48hrs prior to appointment time or not showing to my scheduled sleep study will result in a **$100.00** fee billed to me. I understand my deposit of $100.00 will not be returned to be returned to me.

_____ _____

Patient Signature Date

Appointment Date: _____

Appointment Time: _____

Sleep Lab Phone: 702-780-0300 Ext 413

Email: pulm.5@pulmbhclv.com

Please complete the following packet after the information page

Patient Information Sheet

HOW TO PREPARE FOR YOUR SLEEP STUDY

Do shower. Wash and Dry your hair before coming to the lab.

DO NOT wear makeup, hairspray, gel, mouse, nail polish, or apply lotions to the skin. This will interfere with body contact leads and the quality of your study.

Do eat a regular meal as usual. You may bring in snacks and non-caffeinated drinks as the lab does not have this.

DO NOT drink alcohol or caffeine 8hrs prior to your sleep study.

Do take your regular medications as prescribed. Bring with you any medications you need during the night.

DO NOT take your SLEEP AIDS at home! Bring and wait for the sleep technician to speak with you!

Do bring or wear nightclothes or some comfortable sleepwear. Pajamas or shorts with a T-Shirt are preferred at the sleep lab.

DO NOT wear satin or silky materials or night gowns. Patients are not allowed to sleep nude or just in undergarments. All patients must wear clothing.

What to Expect

When you arrive for your study, the technician will take you to your sleep room. You will complete a before sleep questionnaire. Vitals will be taken. The technician will then apply the monitoring devices. This can take approximately 45mins. You will sleep in a private room and are able to get up throughout the night to use the bathroom. The technician will cover the procedure for calling the tech with you. We provide bedding, including sheets, blankets and pillows. The study will end between by 4:30 am the following morning. The technician is not permitted to discuss your test results or make any treatment recommendations. Please make a follow up appoint to discuss with doctor. Results will be available after 14 business days.

Sleep Study Deposit

A private sleep room has been reserved in your name and coordinated arraignments have been make with a variety of people involved with your sleep study. Many costs are being incurred to properly plan and perform your seep study before you even arrive at our facility. We do not double book any of our patient rooms. There is a **$100.00** deposit for your sleep study. This deposit will be applied to your balance (if any is due) after we receive payment from your insurance or will refunded to you if you have no co-payments and your deductible is fulfilled.

*****Cancellation and No Show******

If you need to cancel or reschedule, we certainly understand and will make every effort to accommodate your needs. Please notify Pulmonology Group Sleep Lab **48 hours in advance of your sleep study**. We have a dedicated phone where you can leave message after hours. Office hours are 8am to 4pm Monday through Friday. Please call the office 702-780-0300 ext 413.

Failure to call in 48hrs prior to appointment time or not showing to your scheduled sleep study will result in an additional **$100.00** fee billed to you. Cancellation Fee/No Show Fee is **YOUR** responsibility and cannot be billed to your insurance company. Your deposit of $100.00 will not be returned and the additional $100.00 will be applied.

_____ _____

Signature Date

_____ Witness Initials

Patient Copy

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_____ _____

Signature Date

_____ Witness Initials

Lab Copy

Privacy Policy

Pulmonology Group, LLC

Sleep Lab

2904 West Horizon Ridge Parkway Suite 100, Henderson, NV 89052 (702) 780-0300

How We Collect Information About You: Pulmonology Group, LLC Sleep Lab and its employees and volunteers collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of physician orders that is either required by law, or necessary to process diagnostic testing through our organization.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to faxes, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your insurance eligibility and to provide you with accurate testing services which may require communication between ADVN and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance,

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information from Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of ADVN. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client’s express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

If you are dissatisfied with the current privacy practices, please call or write to the address above.