Sleep Services of Maryland

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sleepservicesmd.com

Date: _____/_____/_____

PATIENT INFORMATION

First name: _____ Middle name: _____

Last name: _____

Date of Birth: ____/____/____ Sex: M / F Age: _____

Home Phone #: (_____) - _____ - _____ Mobile Phone #: (_____) - _____ - _____

Work Phone#: (_____) - _____ - _____ Email: _____

Address: _____

City: _____ Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorce ☐ Widow Spouse name (if applicable): _____

Race: ☐ White ☐ Hispanic ☐ Black/African American ☐ Asian

☐ American Indian/Alaskan Native ☐ Other _____ ☐ Refused to Report

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Refused to Report

Language ☐ English ☐ Spanish ☐ Russian ☐ Indian (Hindi/Tamil) ☐ Other:

Occupation: _____

Employer name: _____ Employer contact number# _____

Employer address: _____

_____

_____

Who should be notified in case of emergency? _____

Phone #: (_____) - _____ - _____

Referring Physicians Name: _____

Contact information:

_____

_____

Primary Care Physician: _____

Contact information: _____

INSURANCE INFORMATION

Print Name of insurance company

(IF APPLICABLE)

Primary Insurance_____

SECONDARY _____

TERTIARY/OTHER _____

[ ] **SELF PAY** **–NOT DISCLOSED TO INSURANCE --**

FINANCIAL POLICY

I hereby authorize *SLEEP SERVICES OF MARYLAND* to release any information requested with respect to insurance claims and bills as the provider of the service rendered. I hereby authorize payment of insurance benefits directly to the SLEEP SERVICES OF MARYLAND. In instances where I receive payment for services from my own insurance carrier, I agree to endorse form of payment made out to *SLEEP SERVICES OF MARYLAND.*

If your health insurance is covered with Sleep Medicine benefits, we will be happy to bill your insurance. With the provided insurance information, we will verify coverage as a courtesy. However, please note that acceptance of your insurance does not exempt your financial responsibilities and you will be held accountable for any unpaid balances by your plan. *Although we are contracted with most insurance carriers, our services may not be covered by particular insurance plan. We highly recommend you contact your insurance carrier to verify questions regarding coverage for Sleep Medicine.* Moreover, if you have more than one insurance policy please do not assume you will not owe anything.

I understand that I am financially responsible for the charges not covered by insurance.

CONTINUE TO NEXT PAGE.....

FINANCIAL POLICY

PATIENT'S RESPONSIBILITY

As a courtesy, *SLEEP SERVICES OF MARYLAND* verifies your benefits with you insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of *SLEEP SERVICES OF MARYLAND* that payment is due at the time of service. You are accountable for insurance fees (whether it be the copay, deductible or coinsurance) at the time of visit. *Please notify staff if you part of a program (i.e. Care Program) and/or a health savings fund that exempts from this policy. At the conclusion of your visits, you may be billed for any outstanding balances.*

If there is credit, you will be provided a refund promptly.

REFERRALS

Additionally, I understand that if my *insurance carrier requires a written referral from my PRIMARY CARE PHYSICIAN, THE STATE OR OTHER ORGANIZATION.* I am responsible for obtaining the referral prior to service.

APPOINTMENTS

Upon registration, you will receive courteous reminders via email, text or voice message.
Please inform staff if you have a preference on confirmations.

CANCELLATION & NO SHOW POLICY

Doctor's appointment Cancellations ***need to be made 24hours in advance.*** *We understand that there are times when you must miss an appointment due to emergencies, obligations for work/family or life circumstances. However, missing appointments regularly will result in* ***a $25 fee*** *(Not covered by insurance).*

Sleep Study Procedures *Due to a large block of time needed for procedures & staffing requirements, please avoid last minute cancellations****. Cancellations need to be made 48hrs in advance (on weeknights) and 72hours in advance on weekends****. No shows or failure to cancel within allotted time will result in* ***a $100.00*** *fee not covered by your insurance company.*

I understand the terms of the above policies and I am aware of the charges I am responsible for.

Patient/Guardian Signature: _____ **Date** _____

HIPAA Notice of Privacy Practices

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information."Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make
disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members
or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this
notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this
notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask
to speak with our HIPAA Compliance Officer (General Manager) in person or by phone at 404-786-0912.

Your signature below acknowledges that you have received a copy of this Notice of our Privacy Practices.

Patient /Guardian Signature: _____ **Date:** _____/_____/_____

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Date of Birth: _____

I authorize the custodian records of **SLEEP SERVICES OF MD** to release/disclose Sleep Study Results or other information (i.e. Previous medical records, laboratory/pathology, X-Ray, Billing, abstract, summary, pharmacy/prescription records) that may be necessary or beneficial for my care.

****Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Please send records listed to:

[ ] Primary Care Physician\or Referring Physician

[ ] Health Care team

[ ] Others specified below:

Name_____ Contact info_____

Name_____Contact info_____

Name_____Contact info_____

This authorization shall expire a year within a year or greater from the date of signature or when I am no longer receiving services at SSMD (whichever is sooner).

[ ] Check here and do not sign if you, politely refuse Sleep Services of Maryland to disclose or release health information

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian, power of attorney for healthcare, executor)*

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Liaison, 3800 Reservoir Road, N.W. Washington, DC 20007.

A copy of this signed authorization must be given to the individual.

v.10.19.05

Sleep Services of Maryland

EPWORTH SLEEPINESS SCALE

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't 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 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Dozing /or sleepy:
___Chance of falling asleep

SITUATION	CHANCE OF DOZING (circle one)
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place (e.g a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

Medical History & Medication List

Have any of your relatives ever had chronic sleep related problems? ( ) Yes ( ) No

If yes, describe the problem and this person's relationship to you. Describe:

How much alcohol do you typically drink per week? _____ drinks

Do you consider yourself a **light**, **normal** or **heavy sleeper**? *CIRCLE ONE*

Medical History ***(past surgeries, injuries, significant familial conditions)***

Allergies:

List all Currently used drugs or medications below: (including illegal, over the counter & prescribed drugs/medications)

Drug/Medication	Dosage(if know) and reason for taking the medication

Print Name_____ **Date:**_____