PRIME PULMONARY & SLEEP CENTER
*Breathe Well * Sleep Well * Live Better*

PRAMIL VAGHASIA, MD | RUCHI BANSAL, MD

8305 Brimhall Road, Suite 1601 | Bakersfield, CA 93312
t 661.695.6777 | f 661.695.6767

1205 Garces Hwy, Suite 203 | Delano, CA 93215
t 661.725.6910 | f 661.725.6912

www.primepulmonarysleep.com

WELCOME!

Dear Patient,

It is our pleasure to welcome you as a new patient to our practice! We at Prime Pulmonary & Sleep Center strive to provide you with exceptional medical care and superior service.

To help ensure you have the best possible visit, we offer a few tips:

1. **Child's legal guardian to please complete every page of the attached packet in full and bring it with you to your child's sleep study appointment.**

2. **Enclosed you will also find instructions of the night of the sleep study.**

3. **A legal guardian is required to stay overnight with all patient's less than 18 years of age.**

4. **Please bring your insurance card(s) and photo identification. We are required to verify the identity and insurance eligibility of all of our patients.**

<u>If you are unable to keep your appointment FOR ANY REASON,</u>
<u>please notify us at least 48 hours in advance to</u>
<u>avoid a $200 missed appointment fee.</u>
<u>We have set aside your appointment time just for you.</u>

Should any questions or concerns arise before your visit with us, please feel free to contact PPSC by calling: (661) 695 - 6777. We are here to help Monday through Friday from 8:00 am – 6:00pm.

Thank you and we look forward to seeing you soon!

Sincerely,
Our team at PPSC

AASM ACCREDITED Facility Member™ | AASM ACCREDITED HSAT Program Member

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PEDIATRIC SLEEP STUDY - REGISTRATION

Referring Physician:_____ Primary Care Physician:_____

Patient's **LEGAL** Last name: _____ First:_____ Middle Initial: _____

Patient date of birth ___/____/_____Patient Race:_____Patient Ethnicity: _____

Primary home street address:_____Apt #: _____

City:_____ State: _____Zip:_____ Social Security#: _____-____-_____

Primary parent email address: _____

Home phone _____ Cell phone _____ Employer phone _____

Ok to leave a voicemail at the numbers listed? Yes/No If so, preferred # _____

In case of an emergency, who should we notify:_____

Phone:_____

Relationship to patient:_____

Is this person authorized to make medical decisions? Yes/No

If not, please provide a contact that is authorized to make medical decisions:

Name:_____Relationship to patient: _____

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INSURANCE INFORMATION

Please complete insurance information below and provide copy of primary and secondary insurance cards to front office.

Primary Insurance

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SSN#: ____ - ____ - _____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID#: _____ Group#: _____

Employer: _____

Secondary Insurance: YES / NO

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SSN#: ____ - ____ - _____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID#: _____ Group#: _____

Employer: _____

RELEASE AUTHORIZATION

I hereby authorize Prime Pulmonary & Sleep Medicine Center, Inc. to release any and all medical (including dental) information to the above-named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of aligning until revoked in writing. I understand that I may request a copy of this authorization; I have read this authorization and understand if. I HEREBY AUTHORIZE ALL INSURANCE BENEFITS MADE PAYABLE DIRECTLY TO PRIME PULMONARY & SLEEP MEDICINE CENTER, INC., FOR SEVICES RENDERED. I understand I am financially responsible to said doctor (s) for charges whether or not covered by this assignment. I further agree in the event of non-*payment, to bear the cost of collection, and/or court cost and reasonable legal fees should this be required.

_____ _____ _____ _____

PATIENT SIGNATURE **DATE** **GUARDIAN OR INSURED'S SIGNATURE** **DATE**

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby give permission to the staff of Prime Pulmonary & Sleep Medicine Center, Inc. to administer any treatment that may be deemed necessary or advisable in the diagnosis and treatment of my/my dependent's condition.

_____ _____ _____

PATIENT'S SIGNATURE **DATE** **RELATIONSHIP**

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FINANCIAL POLICY AND DISCLOSURE

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable health care services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services provided to patients.

Patients are responsible for the payment of all services provided by Prime Pulmonary & Sleep Center.
I understand and agree that I am financially responsible for all charges for any and all services rendered.

❖ Insurance Policy

- **While we will bill the patient's insurance for services provided, the patient is ultimately responsible for payment for services provided in the event that compensation is not made by the patient's insurance:**
  - I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
  - If we have not received a payment from your insurance company within thirty (30) days, you will be responsible for the balance due.
  - In special cases, we may need your help in contacting your insurance company for the payment of your services.
  - Deductibles, co-payments, and coinsurance will be collected before services are rendered. This includes any medical service or office visit, tele-health visits, routine examination, refraction, testing, and any other screening ordered by the doctor or staff.
  - A card on file is required to facilitate payment of patient responsibility fees. It will be securely maintained with Prime Pulmonary & Sleep Center billing department.
  - I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation of the services I receive and I agree to make payment in full.
  - I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.
  - If the office does not have the proper information for a secondary insurance, the secondary will not be billed, and balance will be my responsibility until secondary insurance information provided in timely. If secondary insurance provided untimely, then I am responsible for the balance.

❖ Overdue, Credit Balances, and Refunds

- All over-due patient balances without a payment plan will be sent to collections.
- All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.
- All refunds will be processed timely according to Prime Pulmonary & Sleep Centers' policy and schedule.

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- **Cancellations**
  - We love to take care of our patients and understand that sometimes the need for a cancellation may arise:
  - If you should need to cancel a pre-scheduled appointment, please notify our office 48 hours in advance so that we may accommodate patients who are on a waiting list for an earlier appointment.
  - Failure to cancel your appointment within 24 hours will result in a $200 charge for a **SLEEP STUDY** and a $100 charge for PULMONARY FUNCTION TESTING.
  - This charge must be paid prior to scheduling your next appointment.

- **To help in this policy, we ask that you assist us by:**
  1. Providing us with current and updated information on yourself and your insurance company.
  2. Presenting an updated photo identification card and insurance card when changes are made.
  3. Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a Self-Pay Patient.

In order to provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician{s) or medical staff. Please discuss any account information with the check-out associate or front desk or ask to speak to our billing department.

By signing this form, I agree I have read and understood the information above.

CHILD'S NAME: _____

CHILD'S DATE OF BIRTH: _____

LEGAL GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

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HIPPA CONSENT FORM

- This consent form allows PRIME PULMONARY & SLEEP CENTER to use and disclose information about me protected under Health Insurance Portability and Accountability (HIPPA) act of 1996.

- By signing this form, you are granting consent to PRIME PULMONARY & SLEEP CENTER to use and disclose your protected health information for the purpose of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practice before you sign this consent, and we encourage you to read it in full.

- PRIME PULMONARY & SLEEP CENTER has the notice of privacy practices available at the front desk for my use if I so request which more completely describes such uses and disclosures. It is also posted in the waiting room.

- I understand that the terms of notice of privacy practices may change and that I may obtain revised notices by mail or by an update to our website.

- I understand that I have the right at any time to revoke this consent, provided I do so in writing. However, the service may still use the information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

- I understand that PRIME PULMONARY & SLEEP CENTER may refuse me further service if I revoke the consent.

CHILD'S NAME: _____

CHILD'S DATE OF BIRTH: _____

LEGAL GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

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Consent and Description of your Child's upcoming Sleep Study

Our staff will be doing everything possible to make your Child's night's stay in the Sleep Center as comfortable as possible. Please read below on what to expect as well during the night. By signing this form, you attest to having read below and give consent for this sleep study.

- Please bring pajamas or a two-piece outfit for your child to wear, as well as any medications your child may need.
- Please shower and wash your hair BEFORE coming to the Lab. Don't use hair spray or oils in your child's hair. This will ensure better adhesion of electrodes.
- Small gold-cupped wires (electrodes) will be filled with cream and taped to or near your child's chin, ears, head, chest, legs and near you're his/her eyes. This takes about one hour.
- All electrodes and sensors are placed using hypoallergenic tape. Please let us know if your child's have a known skin allergy.
- In some cases, after the study has begun, a technologist may need to re-enter your room to reposition sensors or to begin CPAP treatment.
- The technologists are awake all night and you may call them if you need them.
- You will be on a video monitor throughout the night. Recordings are used by Sleep Specialist Physicians only. Recordings are not available for transfer or copy.
- The lab technologist who removes the electrodes in the morning may not be the same technologist who applied the electrodes the night before.
- You are expected to arrive at your scheduled time as other patients are also scheduled on the same night. Late arrivals may forfeit their appointments.
- Except for going to the bathroom, your child must stay in bed throughout the night, resting quietly if awake.
- For patients scheduled for additional recordings the following day, breakfast and lunch facilities are available, but are at cost to the patient. Please bring enough money for these meals. Please bring a lunch-sized cooler for your food items. We do have a refrigerator for patient food. We do have a microwave; please ask for assistance.
- The technologists are highly trained and knowledgeable; however, they may not give you any information regarding your sleep study results or medical condition(s).
- Results will be available in 7-14 days, and may be discussed in detail with your physician.
- Sleep study reports sent to the referring physician(s) only. If you wish to obtain a copy of your report, please contact the Medical Records Department.
- Sleep recordings are highly specialized medical procedures that require time and care in performing and analyzing. Please try to cooperate as best you are able.
- The application of electrodes to his/her head and face area as well as wires to measure breathing and other delicate sensors may disturb his/her sleep somewhat.
- This is normal and your child's cooperation and patience is appreciated will make our job easier and your stay more pleasant.

CHILD'S NAME: _____

CHILD'S DATE OF BIRTH: _____

LEGAL GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

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Pediatric Consent to Leave Messages/Share Information with Family/ Friends

I understand that for PRIME PULMONARY & SLEEP CENTER to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to PRIME PULMONARY & SLEEP CENTER.

Consent for Leaving Messages:

I give consent to PRIME PULMONARY & SLEEP CENTER to leave a message on my voicemail/answering machine about my child's lab results.

☐ Yes ☐ No

Consent for shared information with Family & Friends:

- The Name(s) listed below are family members or friends to whom I grant permission for my child's health care provider and their representatives at PRIME PULMONARY & SLEEP CENTER to verbally discuss their care using their best judgement and grant them permission to disclose health information that is relevant to their care.
- Under the HIPAA Privacy Law, we are permitted, and we may make a professional judgement that certain disclosures are in your best interest even without this signature.
- Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

I understand I have the right to revoke this authorization in writing at any time to the Practice Manager, except to the extent that action has been taken in reliance upon it. I hereby release and hold harmless Houston Pulmonary, Sleep & Allergy Associates, its physicians, staff, employees, agents, and any other persons involved, from any liability, damage or claim that may result from my authorization of the above communications.

Patient's Name (Please Print):_____ **DOB:** _____

Patient or Parent\Guardian Signature:_____ **Date:** _____

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AUTHORIZATION FOR MEDICAL TREATMENT of a MINOR

CHILD NAME: _____ DOB: _____

LEGAL CUSTODY/GUARDIAN NAME: _____

ADDRESS (STREET, CITY, ZIP CODE): _____

PHONE NUMBER: _____

I declare I have legal custody and am the guardian of the child mentioned above.
I give the following permission:

- **To attend appointments with mentioned child at PRIME PULMONARY & SLEEP CENTER.**
- **To receive medical information for the mentioned child**
- **To authorize medical treatment or medical procedures for the mentioned child**

Legal Guardian Signature: _____

Date: _____

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COVID-19 DISCLOSURE FORM

PRIME PULMONARY & SLEEP CENTER is fully prepared to protect our patients from the Covid-19 pandemic and is compliant with CDC/OSHA recommendations.

My child and I have been screened for symptoms prior to arrival and on arrival to Prime Pulmonary & Sleep Center. We have been advised to keep 6 feet distance from any other patients in the office and Prime Pulmonary & Sleep Center has arranged for this as well. I AGREE TO WEAR MY FACE MASK AT ALL TIMES WHILE IN THE CENTER, UNLESS INSTRUCTED OTHERWISE FOR CERTAIN TESTING PURPOSES.

Despite the appropriate preparation and safety measures taken by Prime Pulmonary & Sleep Center, we understand there is still a very small but possible risk of contracting Covid-19 from being on the facility premises. We understand and accept this risk associated with coming to **PRIME PULMONARY & SLEEP CENTER**. If any members or I of my family/friends/close contacts contract the COVID-19 virus, we will not hold **PRIME PULMONARY & SLEEP CENTER**, responsible or liable.

By signing this document, we hereby release PRIME PULMONARY & SLEEP CENTER and its personnel from all legal responsibility of liability that may arise from the act I have authorized above.

CHILD'S NAME: _____

CHILD'S DATE OF BIRTH: _____

LEGAL GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

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COVID-19 SCREENING FORM FOR CHILD AND GUARDIAN

1. In the past 14 days, **have you or your child** traveled or resided outside your state or residence or the United States? (circle one)

   Yes / No
   If yes, Travel Dates and Locations traveled: _____

2. If yes for travel, did **have you and your child** wear a mask and take precautions to avoid COVID-19 exposure? (Circle One)

   Yes / No

3. Have **have you or your child** been Diagnosed with or suspected of having Covid-19 infection? (Circle One)

   Yes / No
   If yes, When/Date? _____

4. In the past 14 days, have **have you or your child** cared for, lived with, or otherwise had close contact with an individual(s) diagnosed with or suspected of having COVID-19 infection? (Circle One)

   Yes / No
   If yes, When/Date? _____

5. Have **you or your child** or anyone in your household has any signs of COVID-19 infection to include but not limited to: Fever over 100 degrees or higher, sore throat, cough, shortness of breath, or diarrhea, sudden loss of smell or taste? (Circle One)

   Yes / No
   If yes, Specify: _____

6. Have **have you or your child** had a positive diagnostic test (e.g., nasopharyngeal, or anterior nares swab) or SARS-COV-2 but never developed symptoms? (Circle One)

   Yes / No
   If yes, when: _____

Date: _____

CHILD Name: _____

LEGAL GUARDIAN Signature: _____

_____

OFFICE STAFF USE ONLY

Patient Temperature: _____ Office Staff Name: _____

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VACCINE INFORMATION

FOR LEGAL GUARDIAN OF CHILD REGARDING COVID-19 VACCINE:

☐ I HAVE RECEIVED THE COVID-19 VACCINE – PLEASE COMPLETE BELOW:

☐ COVID-19 MODERNA VACCINE
FIRST DOSE MONTH/YEAR: _____
SECOND DOSE MONTH/YEAR: _____

☐ COVID-19 PFIZER VACCINE:
FIRST DOSE MONTH/YEAR: _____
SECOND DOSE MONTH/YEAR: _____

☐ JOHNSON & JOHNSON VACCINE – MONTH/YEAR: _____

☐ I PLAN TO RECEIVE THE COVID-19 VACCINE IN: _____

☐ I DO NOT WISH TO RECEIVE THE COVID-19 VACCINE

☐ I DO NOT WISH TO DISCLOSE MY PREFERENCES REGARDING THE COVID-19 VACCINE

FOR CHILD REGARDING THE COVID-19 VACCINE:

☐ MY CHILD IS >12 YEARS OLD AND HAS RECEIVED THE COVID-19 VACCINE

☐ MY CHILD IS <12 YEARS OLD AND HAS NOT RECEIVED THE COVID-19 VACCINE

☐ I DO NOT WISH TO DISCLOSE THIS INFORMATION

CHILD NAME: _____

LEGAL GUARDIAN NAME: _____

LEGAL GUARDIAN SIGNATURE: _____

DATE: _____

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PEDIATRIC HISTORY

Childs Name: _____
Date of Birth: _____ Age: _____
Height: _____ Weight: _____

In preparation for your child's appointment, would you kindly take a moment to answer these routine questions and give the completed form to your child's doctor at the time of his/her appointment. It will help him/her to become oriented quickly to your child's problem so that more time will be available to focus on the main issues and to answer your questions.

Don't worry too much about providing great detail to the questions. The questions are meant simply as an overview.

1. **Please briefly describe the problem/symptoms for which you are seeking a pediatric sleep study:**
   _____
   _____
   _____
   _____

2. **GENERAL HEALTH - Aside from the usual colds and flu's, has your child had any special health problems, major illnesses, surgery, etc.?___If so, please describe:**
   _____
   _____
   _____

3. MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

4. OTHER

If you have any further notes that you may not want to forget to tell the doctor, please write it down here:

_____
_____
_____

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PEDIATRIC SLEEP QUESTIONNAIRE

	Yes	No	Don't Know
While sleeping does your child…			
Snore more than half the time?			
Always snore?			
Snore loudly?			
Have "heavy" or loud breathing?			
Have trouble breathing or struggle to breathe?			
Have you ever…			
Seen your child stop breathing during the night?			
Does your child….			
Tend to breathe through the mouth during the day?			
Have a dry mouth on waking up in the morning?			
Occasionally wet the bed?			
Wake up feeling un-refreshed in the morning?			
Have a problem with sleepiness during the day?			
Has a teacher or other supervisor commented that your child appears sleepy during the day?			
Is it hard to wake your child up in the morning?			
Does your child wake up with headaches in the morning?			
Did your child stop growing at a normal rate at any time since birth?			
Is your child overweight?			
This child often…			
Does not seem to listen when spoken to directly			
Has difficulty organizing tasks			
Is easily distracted by extraneous stimuli			
Fidgets with hands or feet or squirms in seat			
Is "on the go" or often acts as if "driven by a motor"			
Interrupts or intrudes on others (e.g. butts into conversations or games)			

Total Number of "Yes" Responses: _____

If eight or more statements are answered "yes", consider referring for sleep evaluation.

CHERVINE ET AL, PEDIATRIC SLEEP QUESTIONNAIRE: VALIDITY AND RELIABILITY OF SCALES FOR SLEEP DISORDERED BREATHING, SNORING, SLEEPINESS, AND BEHAVIORAL PROBLEMS, SLEEP MEDICINE 2000;1:21-32