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Website: www.sleephealthmd.com Patient Portal:
https://2256.portal.athenahealth.com/

PATIENTS INFORMATION:

_____ _____/_____/_____
LAST NAME FIRST M.I. TODAY'S DATE

_____
ADDRESS CITY STATE ZIP

_____ _____
HOME NUMBER ■ MALE ☐ FEMALE (CIRCLE ONE) DATE OF BIRTH

_____/_____/_____
SOCIAL SECURITY #

PARENTS INFORMATION:

_____ _____ _____ _____/_____/_____
(MOTHER'S NAME) HOME NUMBER CELL PHONE SOCIAL SECURITY #

_____ _____ _____ _____/_____/_____
(FATHER'S NAME) HOME NUMBER CELL PHONE SOCIAL SECURITY #

_____ _____
REFERRING M.D. PRIMARY CARE M.D (IF DIFFERENT)

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with_____, and assign directly to Sleep Health MD all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether paid or not by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
INSURED SIGNATURE / GUARDIAN DATE

Sleep Evaluation Questionnaire

Instructions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION		***Physician Notes***
Child's Name:	Child's gender: ☐ Male ■ Female	
Child's birthday:	Child's Age:	
Child's racial/ethnic background: ☐ White/Caucasian ☐ Black/ African-American ☐ Asian-American ☐ Native-American ☐ Hispanic-Latino ☐ Multi-racial ☐ Other		
What are your major concerns about your child's sleep?		
Sleep History		
Does your child snore? ☐Yes ☐No ☐Don't know Elaborate if needed:		
Describe the snoring: ☐Light ☐Occasional ☐Constant ☐Heavy ☐Other		
Do you ever observe that your child stops breathing, chokes or gasps for air while sleeping? ☐Yes ☐No ☐Don't know		
Does your child awaken with a dry mouth? ☐Yes ☐No ☐Don't know		
Weekday Sleep Schedule The child's usual bedtime on school nights: _____:_____P.M. The child's usual wake time on school days: _____:_____A.M.		
Weekend/Vacation Sleep Schedule The child's usual bedtime on weekend/vacation nights: _____:_____A.M./P.M. The child's usual wake time on weekend/vacation mornings:_____:_____A.M./P.M.		
How long does it take for your child to fall asleep? _____:_____ Is your child difficult to awaken in the morning? ☐Yes ☐No ☐Don't know Elaborate if needed:		

How many times does your child awaken during the night?
☐None ☐1time ☐2 times ☐3times ☐4 times ☐5 or more times

Reason your child awakens:
☐Urinate ☐Shortness of breath ☐Nightmares ☐Screaming ☐Other

Does your child have any of the following?

☐Restless sleep ☐Sweating while sleeping ☐Grinds teeth at night ☐Sleepwalking

☐Sleeptalking, screaming in his/her sleep ☐Trouble staying in bed ☐Growing pains

☐Kicks legs at night ☐Uncomfortable, restless or creepy crawly feeling in limbs

☐Wets bed ☐ Trouble getting up in the morning ☐Daytime sleepiness

☐Falls asleep in school ☐Naps after school ☐Difficulty paying attention at home/school

☐Hyperactivity at home/school ☐Is easily distracted

☐Sees frightening images before falling asleep or awakening

☐Feels weak or loses control of muscles with strong emotion

Nap Schedule

Number of days each week child takes nap: (circle one) 0 1 2 3 4 5 6 7

If child naps, write in usual nap time(s):

Nap 1:____:____☐ a.m. ☐ p.m. to_____:____☐a.m. ☐ p.m.

Nap 2: : ☐ a.m. ☐ p.m. to : ☐a.m. ☐ p.m.

General Sleep

Does the child have a regular bedtime routine? ☐ Yes ☐ No

Does the child have his/her own bedroom? ☐ Yes ☐ No

Does the child have his/her own bed? ☐ Yes ☐ No

Is a parent present when your child falls asleep? ☐ Yes ☐ No

Medical History

Pregnancy/Delivery

Pregnancy ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-term ☐ Post-term

Child's birth weight:

Only child? ☐ Yes ☐ If no, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

Medical and Psychiatric History		
Frequent nasal congestion	No ☐ Yes ☐	Age of diagnosis:
Trouble breathing through his/her nose	No ☐ Yes ☐	Age of diagnosis:
Sinus problems	No ☐ Yes ☐	Age of diagnosis:
Chronic bronchitis or cough	No ☐ Yes ☐	Age of diagnosis:
Allergies	No ☐ Yes ☐	Age of diagnosis:
Asthma	No ☐ Yes ☐	Age of diagnosis:
Frequent colds or flu's	No ☐ Yes ☐	Age of diagnosis:
Frequent ear infections	No ☐ Yes ☐	Age of diagnosis:
Difficulty swallowing	No ☐ Yes ☐	Age of diagnosis:
Acid reflux (gastro esophageal reflux)	No ☐ Yes ☐	Age of diagnosis:
Frequent strep throat infections	No ☐ Yes ☐	Age of diagnosis:
Poor or delayed growth	No ☐ Yes ☐	Age of diagnosis:
Excessive weight	No ☐ Yes ☐	Age of diagnosis:
Hearing problems	No ☐ Yes ☐	Age of diagnosis:
Speech problems	No ☐ Yes ☐	Age of diagnosis:
Vision problems	No ☐ Yes ☐	Age of diagnosis:
Seizures/ Epilepsy	No ☐ Yes ☐	Age of diagnosis:
Morning headaches	No ☐ Yes ☐	Age of diagnosis:
Cerebral palsy	No ☐ Yes ☐	Age of diagnosis:
Heart disease	No ☐ Yes ☐	Age of diagnosis:

High blood pressure	No ☐ Yes ☐	Age of diagnosis:

Sickle cell disease	☐ No ☐ Yes	Age of diagnosis:
Genetic disease	☐ No ☐ Yes	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	☐ No ☐ Yes	Age of diagnosis:
Thyroid problems	☐ No ☐ Yes	Age of diagnosis:
Eczema (itchy skin)	☐ No ■ Yes	Age of diagnosis:
Pain	☐ No ☐ Yes	Age of diagnosis:

Past Psychiatric/Psychological History

Autism	☐ No ☐ Yes	Age of diagnosis:
Developmental delay	☐ No ☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ No ☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks	☐ No ☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ No ☐ Yes	Age of diagnosis:
Depression	☐ No ☐ Yes	Age of diagnosis:
Suicidal thoughts	☐ No ☐ Yes	Age of diagnosis:
Learning disability	☐ No ☐ Yes	Age of diagnosis:
Drug use/abuse	☐ No ☐ Yes	Age of diagnosis:
Behavioral disorder	☐ No ☐ Yes	Age of diagnosis:
Psychiatric Admission	☐ No ☐ Yes	Age of diagnosis:

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

Notes:

Current Medication List

Please list any medications your child currently takes:

Medicine	Dose	How often?
1.		
2.		
3.		
4.		

Long-Term medical problems

If your child has long-term medical problems, please list the three you think are most important.

1.

2.

3.

Surgeries/Hospitalizations

Has your child ever had his/her tonsils removed? ☐ Yes Age of surgery:

Has your child ever had his/her adenoids removed? ☐ Yes Age of surgery:

Has your child ever had ear tubes? ☐ Yes Age of surgery:

Please list any additional hospitalizations or surgeries:

Health Habits

Does your child drink caffeinated beverages?
(e.g., Coke, Pepsi, Mountain Dew, iced tea) ☐ No ☐ Yes Amount per day:

School Performance

Current School Performance (if school-aged)

Your child's grade:
Has your child ever repeated a grade? ☐ No ☐ Yes

Is your child enrolled in any special education class? ☐ No ☐ Yes

How many school days has your child missed so far this year?

How many school days did your child miss last year?

How many school days was your child late so far this year?

How many school days was your child late last year?

Child's grades this year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Family Information

Mother

Age:

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried

Education:

Work: ☐ Unemployed ☐ Part-time ☐ Full-time

Occupation:

Family Information

Father

Age:

Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried

Education:

Work: ☐ Unemployed ☐ Part-time ☐ Full-time

Occupation:

Persons Living in Home

Name:	Relationship	Age

Family Sleep History

Does anyone in the family have a sleep disorder? Yes ☐ No ■

If yes, mark the disorder(s):

Insomnia	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other: Describe:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

Referral

Who asked that your child be seen by a sleep specialist?

_____ Pediatrician/Family physician

_____ Child's parent or guardian

_____ Surgical specialist (e.g., ENT)

_____ Pediatric specialist (e.g., allergist, neurologist, pulmonologist)

_____ Mental health specialist (e.g., psychiatrist, psychologist, social worker)

_____ School teacher, nurse, counselor

_____ Child himself/herself

_____ Other:

Screening Questionnaire:
Obstructive Sleep Apnea

Name: _____

Person completing form: _____ Date: _____

Please answer the following questions as they pertain to your child in the past month.

1. While sleeping, does your child:	○ Y	○ N	○ DK
Snore more than half the time?	○ Y	○ N	○ DK
Always snore?	○ Y	○ N	○ DK
Snore loudly?	○ Y	○ N	○ DK
Have "heavy" or loud breathing?	○ Y	○ N	○ DK
Have trouble breathing, or struggle to breathe?	○ Y	○ N	○ DK
2. Have you ever seen your child stop breathing during the night?	○ Y	○ N	○ DK
3. Does your child:			
Tend to breathe through the mouth during the day?	○ Y	○ N	○ DK
Have a dry mouth on waking up in the morning?	○ Y	○ N	○ DK
Occasionally wet the bed?	○ Y	○ N	○ DK
4. Does your child:			
Wake up feeling un-refreshed in the morning?	○ Y	○ N	○ DK
Have a problem with sleepiness during the day?	○ Y	○ N	○ DK
5.			
6. Has a teacher or other supervisor commented that			
Your child appears sleepy during the day?	○ Y	○ N	○ DK
7. Is it hard to wake your child up in the morning?	○ Y	○ N	○ DK
8. Does your child wake up with headaches in the morning?	○ Y	○ N	○ DK
9. Did your child stop growing at a normal rate at any time since birth?	○ Y	○ N	○ DK
10. Is your child overweight?	○ Y	○ N	○ DK
11. This child *often:*			
Does not seem to listen when spoken to directly	○ Y	○ N	○ DK
Has a difficulty organizing tasks and activities	○ Y	○ N	○ DK
Is easily distracted by extraneous stimuli	○ Y	○ N	○ DK
Fidgets with hands or feet or squirms in seat	○ Y	○ N	○ DK
Is "on the go" or often acts as if "driven by a motor"	○ Y	○ N	○ DK
Interrupts or intrudes on other (e.g., butts into conversations or games).	○ Y	○ N	○ DK

Screening Questionnaire:
Restless Legs Syndrome

1. **Does your child have "growing pains"? (check one)**

_____ Never_____Occasionally _____Sometimes_____Frequently
(Less than 1x/month) (1-2x/month) (1-2x/wk to daily)

2. **Does your child complain of uncomfortable or funny feelings (creeping, crawling, tingling) in his/her legs? (check one)**

_____ Never_____Occasionally _____Sometimes_____Frequently
(Less than 1x/month) (1-2x/month) (1-2x/wk to daily)

3. **Does your child:**

	Yes	**No**	**Don't Know**
A. Notice funny feelings in his/her legs (or do they seem worse) when lying down Or sitting?	☐	☐	☐
B. Have partial relief with movement (Wiggling feet, toes, or walking?)	☐	☐	☐

4. **Does your child appear restless while sleeping (thrashing around, banging feet against the wall, twisting covers or falling out of bed)? (Check one)**

_____☐ Never_____☐Occasionally _____☐Sometimes_____☐Frequently
◯**(Less than 1x/month)** ◯**(1-2x/month)** ◯**(1-2x/wk to daily)**

5. **Does your child seem more restless, fidgety or hyperactive then most children his/her age?**

_____☐ Never_____☐Occasionally _____☐Sometimes_____☐Frequently
◯**(Less than 1x/month)** ◯**(1-2x/month)** ◯**(1-2x/wk to daily)**

6. **A. Has anyone in the family (including grandparents, aunts/uncles) been diagnosed with restless legs or periodic leg movements during sleep)?**
b. Does anyone in the family have severe problems falling or staying asleep? If so, who?
_____. Type of problem, if known:_____

7. **How often, on average, does your child consume caffeine-containing beverages or food? (coffee, tea, cola beverages, chocolate)**

_____ Never_____Occasionally _____Sometimes_____Frequently
◯**(Less than 1x/month)** ◯**(1-2x/month)** ◯**(1-2x/wk to daily)**

8. **Has your child ever been diagnosed and/or treated for anemia?**
Yes___No___Don't know____
Date, type of anemia and treatment, if known: _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations, Assignment of Benefits and Consent to Obtain Medication History

I understand that as part of my healthcare, this organization Aaron B. Morse, M.D./Sleep Health MD originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a:

- basis for planning my care and treatment
- means of communication among the many health professionals who contribute to my care
- source of information for applying my diagnosis and surgical information to my bill
- means by which a third-party payer can verify that services billed were actually provided
- tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Notice of Information Practices

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. If you have any questions regarding billing, please contact our billing compliance officer. **Intial here** _____

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Aaron B. Morse for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for any amount not covered by insurance. **Initial here** _____

Consent to Obtain Medication History

I authorize **Sleep Health MD** to view and download my medication history from SureScripts.
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here and it may include prescriptions back in time for several years. **Initial here** _____

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____	_____
Patient Name (Print) Date	Name (Print of Authorized Rep) Date
_____	_____
Signature Date	Signature (Authorized Rep. & Relationship) Date

Financial Policy

Patient Name:_____ **Date of Birth:**_____

Thank you for choosing Sleep Health MD as your healthcare provider. We are committed to your treatment being a successful experience. Our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

WE ACCEPT MASTERCARD, VISA, DEBIT CARDS, DISCOVER, CHECKS, MONEY ORDERS AND CASH. ASK ABOUT OUR "CARD-ON-FILE" SERVICE.

Non-Contracted / Indemnity Insurance Plans: We will bill your insurance company as a courtesy. We require you to pay in full at the time of service. Your insurance company will send payment directly to you.

Co-Payment: Your insurance carrier requires that all co-payments and deductible amounts be collected at time of service. A billing fee of $35 will be added to your balance if you do not make your payment at the time of service. Any portion of the fee for sleep studies not covered by your insurance plan is due prior to the performance of the study

Referrals: You are responsible for providing any required referrals or authorizations in advance of your appointment. We will estimate the amount due to the best of our ability.

Medicare: As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co-insurance and we must, by Medicare regulation, collect it. We will be happy to bill your secondary payer as well.

Secondary Insurers: Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult regardless who the policy holder is for the insurance plan(s).

Missed Appointments: There is a $35 missed appointment fee if you cancel or reschedule an appointment with less than 24 hours advance notice or if you fail to arrive for your appointment.

Sleep Study Cancellation or "No-Show": Failure to appear and/or have not cancelled your scheduled study more than 48 hours prior to your study appointment will result in a charge of 10% of the study fee, up to $400.

Minor Patients: The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

Your Personal and Insurance Information: We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

Forms: There is no charge for forms completed as part of an office visit. There may be a charge for filling out forms based on your medical records when it is not done at the time of an appointment. Fees vary depending upon the form, including school forms, child care forms, immunization cards, disability forms, etc. However, there will be a $25 charge for copying materials from your chart when done other than at the time of a visit including the transfer of records to another facility.

Returned Check Fee: There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will no longer accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

_____ Date: _____

Signature of Patient or Responsible Party

_____

Printed name of Patient or Responsible Party