SOUND SLEEP HEALTH

Patient Information

Date:		
First Name:	**MI:**	**Last Name:**
Address:		City/State/Zip:
Date of Birth:	Age:	Gender: Male ❑ Female ❑
Social Security #:		Marital Status: S ❑ M ❑ D ❑ W ❑
Home Phone (Landline):		Cell Phone:
Work phone: Ext:		Preferred Phone (circle one): Home Cell Work
Patient Employer:		
Occupation:		
Email:		Ok to communicate by email? Yes ❑ No ❑ Ok to communicate by SMS/Text? Yes ❑ No ❑
Spouse/Guardian:		Spouse Guardian employer:
How did you hear about us?		

Primary Insurance Company:
Insurance Co-pay (due at time of service):
Subscriber Name:
Insurance ID #:
Group #:
Secondary Insurance Company:
Subscriber Name:
Insurance ID #:
Group #:

Referring Healthcare Provider:
Primary Care Physician:
Preferred Pharmacy:
Family Dentist:

Please list the name of someone who we may contact in case of an emergency **(REQUIRED)**		
Name:	Relationship:	Phone:

I authorize Sound Sleep Health to release my medical records to my insurance company and other medical providers.

_____ Date: _____

(Signature)

SOUND SLEEP HEALTH

This questionnaire helps us zero in on your sleep problems. Please be as detailed and complete as you can.

What is your occupation? If retired, what did you do before retiring? _____

List your main sleep problems (please estimate how long you've had each problem)

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

Have you ever had sleep testing? Yes____ No____ What year?_____ Name of sleep center where testing was done:
Are you currently using CPAP or an oral appliance for sleep apnea? Yes____ No____ Supplier:
Have you had airway surgery for snoring or sleep apnea? Yes____ No____ Surgeon: Date:
What medications or supplements, if any, have you tried for your sleep problem(s)?
What other things have you tried to help your sleep problem(s)?

Please feel free to give us any additional information that you think would help us understand your sleep problem:

_____

_____

_____

_____

Please give us a run down of your work days and days off. If you are a shift worker, if there is a lot of day-to-day variation or if you need more space to answer completely, please use the comments section below.

	Work days	Weekends, holidays or days off from work
What time do you get into bed?		
Any bedtime "rituals" (meditation, bath, etc)?		
Read, watch TV or listen to music in bed?		
How long to fall asleep once in bed?		
How many times do you wake up?		
What kinds of things wake you up?		
How long on average to fall back asleep?		
During what hours do you have your best sleep?		
About how many total hours do you sleep?		
When are you usually awake by?		
When do you get out of bed?		
By what time are you fully alert?		
What part of the day are you at your best?		
What is the drowsiest part of your day?		
Do you nap during the day? How long?		
When do you eat supper?		
When and how often do you exercise?		

Additional comments:

_____

_____

Your current weight (pounds)_____ Your height (feet/inches)_____ Your neck size:_____
Over the past year, has your weight been: Increasing: □ Decreasing: □ Stable: □

Put a check by any of your blood relatives who have had any of the conditions listed:

RELATIVE:	Grandparents	Father	Mother	Siblings	Cousins	Children
Loud Snoring:						
Obstructive Sleep Apnea:						
Severe Sleepiness:						
Insomnia:						
Restless Legs:						
Obesity:						
High Blood Pressure:						
Diabetes:						
Heart Disease:						
Cancer:						
Autoimmune disorder (lupus, rheumatoid arthritis, etc)						
Depression:						
Anxiety:						
Bipolar Disorder:						
Autism or Asperger Syndrome:						
ADD or ADHD:						
Alcohol or Substance Abuse:						
Dementia:						
Other (please list):						

Birth order: I was the _____ of _____ children	What education level have you completed?
Did your mother have any problems during her pregnancy?	Did you serve in the military? If so, in what roles?
Any MAJOR childhood illnesses?	Married or partnered?
Have you ever had a concussion? If yes, how many?	Do you have children? If so, what are their ages
Any issues with abuse or neglect in childhood?	What do you like to do in your spare time?
Any teeth pulled in childhood or adolescence?	
Does WORK stress impact your sleep? Not at all: □ A Little: □ Somewhat: □ A Lot: □ List stressors, if any:	
Does DOMESTIC stress impact your sleep? Not at all: □ A Little: □ Somewhat: □ A Lot: □ List stressors, if any:	

Additional comments:

Do you smoke tobacco? If you quit smoking, how long ago:	Yes □	No □	If yes, how much per DAY on average?
Do you drink alcohol? If you quit drinking, how long ago:	Yes □	No □	If yes, what, how much and how often?
Caffeinated drinks?	Yes □	No □	If yes, what, how much and what time of day?
Cannabis or other recreational drugs?	Yes □	No □	If yes, what, how much and how often?

Current Medical Problems, if any (i.e., high blood pressure, diabetes, heart problems, low thyroid, depression, etc)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Past major medical problems not listed above, if any (i.e., injury to head, face, mouth, neck or teeth, surgeries, major illnesses, accidents) – please list approximate year of occurrence

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Current medications, vitamins and supplements (please list doses also)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please list any prescription medications that you've taken then discontinued (other than antibiotics or other short-term treatments) – please list the reason for discontinuation, if you can remember

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies or reactions to medications (please indicate what problem the medication caused)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you ever experienced any of the following symptoms or situations?

Yes	No	Sleep walking or talking	Yes	No	Hallucinations or dreamlike images while falling asleep or waking up
Yes	No	Waking up to eat			
Yes	No	Frequent nightmares			
Yes	No	Acting out dreams while asleep?			**MEN ONLY**
Yes	No	Talking, yelling or groaning while sleep?	Yes	No	Problems obtaining or maintaining erections
			Yes	No	Awakening with painful erections
Yes	No	Buckling of knees during emotions like laughing, happiness or anger			**WOMEN ONLY**
			Yes	No	Awakened by painful menstrual cramps
Yes	No	Sagging of the jaw or neck during emotions like laughing, happiness or anger	Yes	No	Sleep problem seems to be related to menstrual cycle
Yes	No	Frozen in place/unable to move body while waking up or falling asleep	Yes	No	Sleep problem started or got worse around menopause

Read the following situations and use the scale provided to rate your sleepiness.
0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing;

SITUATION	CHANCE OF DOZING				
Sitting and Reading	0	1	2	3	
Sitting inactive in a public place (theater, meeting)	0	1	2	3	
Passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (without alcohol)	0	1	2	3	
In a car, stopped for a few minutes in traffic	0	1	2	3	
Watching TV	0	1	2	3	Total
Sum:					

Using the scale below, please list how often you've experienced the following symptoms or situations recently. Circle only one letter per line.

D	F	O	S	N	?
Daily or almost daily	Frequently (1 – 3 times per week)	Occasionally (1 – 3 times per month)	Seldom (less than once per month)	Never	Not sure

D F O S N ? **1** Nodding off without meaning to
D F O S N ? Difficulty getting up in the morning
D F O S N ? Daytime napping
D F O S N ? Afternoon drowsiness
D F O S N ? Evening drowsiness

D F O S N ? **2** Drowsiness interferes with work or school
D F O S N ? Drowsiness makes it difficult to drive
D F O S N ? Drowsiness interferes at home
D F O S N ? Drowsiness interferes with social life

D F O S N ? **3** Easily fatigued/need to rest frequently
D F O S N ? Fatigue interferes with work or school
D F O S N ? Fatigue interferes at home
D F O S N ? Fatigue interferes with social life

D F O S N ? **4** Thoughts won't quiet down at bedtime
D F O S N ? Take longer than an hour to fall asleep
D F O S N ? Wake three or more times per night
D F O S N ? Can't get back to sleep if awakened
D F O S N ? Frustrated because of inability to sleep

D F O S N ? **5** Feeling down or blue much of the day
D F O S N ? Decreased interest in social activities
D F O S N ? Feelings of guilt or remorse
D F O S N ? Decreased interest in sex
D F O S N ? Change in appetite (□up or □down)
D F O S N ? Thoughts that life is not worth living

D F O S N ? **6** Difficulty learning new things
D F O S N ? Difficulty getting organized
D F O S N ? Overwhelmed by complicated tasks
D F O S N ? Difficulty staying focused on reading material
D F O S N ? Difficulty staying focused at work or school

D F O S N ? **7** Anxious, nervous or edgy much of the day
D F O S N ? Fear of being in tight, enclosed spaces
D F O S N ? Easily startled
D F O S N ? Nightmares or disturbing dreams
D F O S N ? Recurrent obsessive thoughts

D F O S N ? **8** Irritable much of the day
D F O S N ? Easily upset
D F O S N ? Impatient with others
D F O S N ? Loss of temper/anger outbursts

D F O S N ? **9** Restless/uncomfortable feelings in the body
D F O S N ? Urges to move arms or legs while awake
D F O S N ? Urge to move interferes with getting to sleep
D F O S N ? Twitching or jerking of limbs while awake
D F O S N ? Tossing and turning while asleep

D F O S N ? **10** Snoring
D F O S N ? Breathing stops while asleep
D F O S N ? Breathing alternates between shallow and deep while asleep
D F O S N ? Awakened by gasping or choking

D F O S N ? **11** Awakened by children
D F O S N ? Awakened by bed partner
D F O S N ? Awakened by pets
D F O S N ? Awakened by outside noises or lights
D F O S N ? Awakened by uncomfortable mattress

D F O S N ? **12** Fall asleep watching TV
D F O S N ? Fall asleep on couch or recliner
D F O S N ? Use alcohol to help fall asleep
D F O S N ? Use sleeping medication to help fall asleep
D F O S N ? Use food to help fall asleep

D F O S N ? **13** Stuffy or runny nose
D F O S N ? Sinus fullness or pain
D F O S N ? Tooth grinding or clenching
D F O S N ? TMJ (jaw joint) pain
D F O S N ? Hoarseness
D F O S N ? Sore throat

D F O S N ? **14** Wheezing
D F O S N ? Coughing
D F O S N ? Shortness of breath
D F O S N ? Rapid or irregular heartbeat
D F O S N ? Swelling of the extremities (edema)
D F O S N ? Chest pain or heaviness

D F O S N ? **15** Acid reflux/heartburn
D F O S N ? Abdominal pain or cramping
D F O S N ? Diarrhea
D F O S N ? Bloating or belching

D F O S N ? **16** Night sweats
D F O S N ? Wake up feeling hung over
D F O S N ? Waking with a dry mouth
D F O S N ? Get up to urinate more than once per night

D F O S N ? **17** Achy joints
D F O S N ? Achy or tender muscles
D F O S N ? Awakened by muscle or joint pain
D F O S N ? Awakened by muscle cramps

D F O S N ? **18** Morning headache
D F O S N ? Daytime or evening headache
D F O S N ? Back pain
D F O S N ? Numbness, burning or tingling of extremities
D F O S N ? Carpal tunnel (aching of wrists or forearms)
D F O S N ? Pain interferes with getting to sleep
D F O S N ? Awakened by pain after falling asleep

D F O S N ? **19** Not satisfied with quality of sleep
D F O S N ? Not satisfied with amount of sleep
D F O S N ? Not satisfied with daytime energy
D F O S N ? Not satisfied with daytime alertness

OFFICE POLICIES

Prescription Refills

For our patients who need refills on their medication(s), please contact your pharmacy directly to request a refill. Since it usually takes 5-7 business days to get a refill, please contact your pharmacy 5-7 days before you are completely out of the medication(s). Please be aware that some medications may require an office visit for regular monitoring and refills in accordance with state laws. These medications may include but are not limited to: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®).

HIPPA / Privacy Policies

By signing below, I am acknowledging that I have been provided with a copy of Sound Sleep Health's **Notice of Privacy Practices** and have reviewed them. A copy is also available on Sound Sleep Health website.

SIGNATURE: _____ **DATE:**_____

SOUND SLEEP HEALTH

AUTHORIZATION TO COMMUNICATE VIA SMS / TEXT COMMUNICATION

Sound Sleep Health has the ability to send you appointment reminders, outstanding balance reminders and more through SMS / Text Messaging. Please read the following to let us know if you would like to opt-in or opt-out of use with this form of communication.

□ **Authorize SMS / Text Messaging** I authorize Sound Sleep Health Administration to send me messages me via SMS / text messaging to confirm my scheduled appointments to my current cell phone number and their online scheduler. Current cell phone number: _____
□ **Change phone number**: I am changing the email address to be used for communications with Sound Sleep Health New email address (please print): _____
□ **Discontinue SMS / Text Communication:** I no longer wish to communicate via SMS / Text Communication.

• I understand that any messages between my provider and me/the patient may become part of my medical record. These transmissions may be disclosed in accordance with future authorizations.
• I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
• I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for Sound Sleep Health benefits if I refuse to sign this Authorization.
• I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication
Patients and/or personal representatives who want to communicate with their health care providers by email / portal should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. SMS / Text communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
2. Highly sensitive or personal information should only be communicated by SMS / Text Communication at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
3. Staff other than the health care provider may read and process SMS / Text communication.
4. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
5. Sound Sleep Health will not be liable for information lost or misdirected due to technical errors or failures.
6. **Text / SMS communication is not secure. Personal health information sent by SMS / Text Communication is done so at your own risk. Signing this form, you are acknowledging that are you aware that this method is not secure and can be intercepted at any time by someone other than Sound Sleep Health. You are also signing that you will not hold Sound Sleep Health responsible should your information be intercepted.**

I have read and understand the Alert for Electronic Communications and agree that SMS/ text communication may include protected health information about me / the patient, whenever necessary.

_____ _____ _____
Patient/representative's signature Relation Date

_____ _____
Patient's printed name Date of birth

Please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing.

SOUND SLEEP HEALTH

AUTHORIZATION TO SEND PROTECTED HEALTH INFORMATION BY SECURE EMAIL AND/OR PATIENT PORTAL

Sound Sleep Health and you have the ability to send secure messages through a secure email program and/or Patient Portal. Please read the following to let us know if you would like to opt-in or opt-out of use with this communication.

□ **Authorize email communication / use of Patient Portal:**
I authorize the Sound Sleep Health Clinical Staff to email me regarding the course of my medical care, treatment and diagnostic test results, including information concerning mental health, substance abuse and sexually transmitted disease as well as messaging with questions regarding my account through the use of a secure email or Patient Portal.

□ I authorize Sound Sleep Health Administration to message me with questions regarding my account status.

E-mail address (please print): _____

□ **Change email address**: I am changing the email address to be used for communications with Sound Sleep Health
New email address (please print): _____

□ **Discontinue email / Updox Patient Portal communication:** I no longer wish to communicate via email / Updox Patient Portal.

• I understand that any messages between my provider and me/the patient may become part of my medical record. These transmissions may be disclosed in accordance with future authorizations.
• I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
• I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for Sound Sleep Health benefits if I refuse to sign this Authorization.
• I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication
Patients and/or personal representatives who want to communicate with their health care providers by email / portal should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. Email communication / use of Updox Patient Portal is a convenience and is not appropriate for emergencies or time-sensitive issues.
2. Highly sensitive or personal information should only be communicated by email / Patient Portal at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
3. Employers generally have the right to access any email received or sent by a person at work.
4. Staff other than the health care provider may read and process email.
5. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
6. Sound Sleep Health will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email / portal messages may include protected health information about me / the patient, whenever necessary.

_____	_____	_____
Patient/representative's signature	Relation	Date
_____	_____	
Patient's printed name	Date of birth	

Please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing.

FINANCIAL & CREDIT CARD ON FILE POLICIES

Credit Card on File Policy

At Sound Sleep Health, we offer a credit/debit card on file service as a convenient method of payment for the portion that your insurance does not cover, and for which you are liable. With a card on file, you can use it to pay for co-pays, unmet deductibles, and coinsurance. You also won't have to worry about getting a statement or sending a check for payment. We will send you an email notification 5 days before we charge your card. We will also send you a payment receipt. Your credit card information is kept confidential and secure by Evalon, Inc., and office members do not have access to credit card information.

Payments from your card are processed after the claim has been filed and processed by your insurer, and after the insurance portion of the claim is paid and posted to the account. However, if your insurance company denies coverage or does not pay your claim within 45 days, the balance will automatically be billed to you. Of course, if we receive dual payments, you will be refunded.

If there are insufficient funds on your credit/debit card, or you choose not to have a credit card on file, there will be an administrative $5 fee added to your statement.

We understand there are legitimate reasons you might not have a credit or debit card (declared bankruptcy, maxed out, or declared unworthy of credit). If this is the case, we will work out a payment plan with you.

Insurance and Billing Information

We participate with most insurance plans. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you cannot provide us with the correct insurance information at the time of visit, you are responsible for paying for the office visit: new patient visit - $300, and follow up appointment - $175.

As a convenience, we submit the bill for physician visits and diagnostic tests to your insurance carrier. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Of course, if we receive dual payment on your account, you will be refunded. If your insurance changes, please notify us as soon as possible.

If you are not insured by a plan we do business with, payment in full is expected at each visit. Understanding your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Some insurance policies do not include coverage for sleep disorders. Please call your insurance carrier before your appointment to check your benefits so that you have advance knowledge of your financial responsibility as well as if any referrals will be necessary.

For diagnostic tests, we require a partial payment in the amount of $250 at the time of service.

Co-payments, co-insurance and deductibles

Every insurance plan splits the responsibility for health care costs between the insurer and the patient by setting co-pays, co-insurance and deductibles. For an example, see the section titled, "Covered by insurance", below. We are required by our contracts to bill our patients for co-pays, co-insurance and deductibles. Failure

on our part to bill the patient portion of a bill can be considered fraud. Please help us by paying your co-payment and any outstanding co-insurance or deductible balance at the time of each visit.

Cancellation Policy

Office visits and sleep studies involve a large commitment of resources on our part. If you cannot come in for an appointment or study, please contact us **at least 24 hours in advance** to allow us to fill your slot.
Office Visits: If you do not show or don't call to cancel your appointment at least 24 hours in advance, you will be billed a **$50 no-show/cancellation fee**.
Sleep Studies: A **$175 no-show/cancellation fee** applies to any sleep study.

Self-pay

If you do not have insurance or wish to pay out of pocket, we require payment in full at the time of service for office visits and full payment in advance for sleep testing.

Default

Any unpaid patient balances after 50 days or any missed payment for 15 days of a payment plan are considered in default and are transferred to a collections agency. Once your balance is with a collections agency, we may no longer make any payment arrangements with you.

I agree to be responsible for any amounts not paid by my insurance plan. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fees. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

I acknowledge that I read the financial policy and agree to the terms of payment due:

_____ _____
Patient's Signature Patient's Date of Birth

_____ _____
Patient's Printed Name (First and Last) Date

FINANCIAL POLICY

How much will I have to pay for my visit or diagnostic test?

The health insurance system is very complex, and unfortunately, we simply cannot know exactly how much a certain service will cost you. We strongly encourage you to contact your insurance company and ask them about your share of the costs. We are happy to provide you the billing codes for each procedure we do.

Each insurance company has its own schedule of rates for specific services. Your individual rate depends not only on the brand of insurance you have, but also on which level of plan you have. Also, your share of the costs depends on the amount of your deductible, coinsurance and co-pay.

The rates below are for general guidance. Most of our patients are responsible for substantially less than the amounts indicated.

New patient office visit:	up to $300
Follow up visit:	up to $225
Sleep Apnea diagnostic home tests:	up to $1350
Other Sleep Disorders diagnostic home tests:	up to $3600
In-lab diagnostic test, polysomnography (PSG):	up to $1400
In-lab diagnostic test, PSG/MSLT:	up to $2250
Visit with DME technician:	up to $105
CPAP first month rental and supplies: (for self-pay patients)	around $300
Phone call with provider: (not covered by insurance)	up to $100
Phone call with DME technician: (not covered by insurance)	$25

"Covered by insurance": what does this mean?

What it DOES NOT mean: that insurance will pay for 100% of the cost.

What it DOES mean: that insurance considers the service or device to be medically necessary and will either apply the cost to your deductible or, if your deductible has been met, will pay for most of the cost, minus your co-insurance and/or co-pay.

Example 1: say you have a plan with a $1000 deductible and 10% co-insurance, and none of your deductible has been met for this year. You get a diagnostic test that is covered by your insurance and which costs $1500.

- You will need to pay $1000 to meet your deductible.
- The remaining $500 will be shared 90%/10% between your insurance and you.
- Your total responsibility will be $1000 plus $50, or $1050. Insurance will contribute $450 toward this bill.

Example 2: your doctor next determines that you need a medical device costing $1500.

- Your deductible for the year ($1000) has already been met (woohoo!), so the $1500 device cost will be shared 90%/10% between your insurance and you.
- Your total responsibility will be $150. Insurance will contribute $1350 toward the second bill.

Summing it all up:

- You got a total of $3000 of services and devices. You paid $1050 plus $150, or $1200, and you fully met your deductible for the year. Insurance contributed $1800 toward the cost, or 60%.
- You're in the bonus zone now, because any further health care expenses will be covered at 90%/10% for the remainder of the year.

Important Notes:

- Every insurance plan is different! Please use the above examples only as a general guide to the rules of the game.
- All insurance plans have limitations. You are responsible to verify that your insurance covers sleep testing and medical devices, if needed.

High Deductible Logic:

- Each January, we have noticed that some patients are reluctant to seek health care because they are facing a large deductible.
- However, we have found that **most of our patients with high deductible plans go through their deductibles** by the end of each year.
- Therefore, we recommend not postponing necessary health care when facing a high deductible – you'll likely spend it this year anyway, whether now or later.