Advanced Sleep Medicine Services, Inc.
The Sleep Experts®

Home Sleep Test (HST) Set-up CHECKLIST

Please place a check mark next to each item.

Completed by Patient	Verified by Technician	
☐	☐	**Home Sleep Test (HST) Instructions** (Page 1)
☐	☐	**Patient Information** (Page 2)
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☐	☐	**HST Set-up Checklist** (Page 8)

Provided by Patient	Received by Technician	
☐	☐	**Primary & Secondary Insurance Cards**
☐	☐	**Driver's License or Photo ID** (or parent's for patients under 18 years old)
☐	☐	**Copay or Deductible**

HST Return Appointment

Date:	
Time:	
Location:	

<u>Attention technician</u>: Scan the originals into the patient account in Brightree and give the original paperwork to the patient to take home.

Technician Signature: _____

Revised November 2015

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Home Sleep Test (HST) Instructions

1. Your physician has ordered an unattended home sleep test (HST) to diagnose or rule out sleep apnea. This test cannot diagnose any other sleep disorders.

2. This device cannot be used at the same time as a PAP device or nocturnal oxygen. If you must sleep with a PAP device or oxygen, please speak with your doctor before testing.

3. Advanced Sleep Medicine Services, Inc. will verify your insurance coverage for this test. If requested, we can provide an estimate of your financial responsibility. For exact coverage information, you must contact your insurance provider.

4. Please test on the night that you first receive the device. It is important that you complete your test and return the device as scheduled. If for any reason you are unable to test, please contact Advanced Sleep Medicine Services, Inc. immediately at (877) 775- 3377 Option 3.

5. Please contact your referring physician in 7-10 business days for your results and recommendations.

6. Based on the results of your test and the recommendation of your physician, you may require additional service such as an in-center sleep study or PAP device set-up. Please discuss next steps with your physician. The technologist administering your test cannot provide any information about your diagnosis or treatment.

PLEASE SIGN HERE:

Patient/Caregiver Signature **Relationship to Patient** **Date**

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Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F

Patient Name_____Social Security Number_____-_____-_____
First Middle initial Last

Home Address_____
Street City State Zip

Date of Birth___/___/____ Home Phone# (____)____-_____ Cell Phone #(____)____-_____

Email Address: _____

Your Occupation_____Employer_____ Work # (____)____-_____
Spouse's Name_____ Employer_____ Work # (____)____-_____
Emergency Contact_____Relationship_____Phone (____)____-_____

Guardian Information *(MUST be completed if patient is under 18 years old)*

*Mother's Name*_____ *Father's Name*_____

Address_____Address_____

Phone # Cell(___)____-____ Home(___)____-____ Phone # Cell (___)____-_____Home(___)____-_____

SSN # ____-____-_____ DOB___/___/_____ SSN # ____-____-_____ DOB ____/____/_____

Employer_____ Employer_____
Address_____ Address_____
Work# (_____)_____ Work# (_____)_____

Billing Information

Name of Person Financially Responsible for Account_____
Relationship to Patient_____ SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip

Insurance

Insured by: Self Spouse Father Mother Grandparent Other _____
Primary Insurance Company _____ ID#_____
Policy Holder_____SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip
Secondary Insurance Company _____ ID#_____
Policy Holder_____SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip

EPWORTH SCALE

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

Height:	Weight:	BMI:	SpO2:

Instructions: How likely are you to doze off in the following situations (in contrast to just feeling tired)? Even if you have not done some of these things, try to work out how these situations would affect you.

Use the following scale:

0 = ***would never doze***
1 = ***slight chance of dozing***
2 = ***moderate chance of dozing***
3 = ***high chance of dozing***

Situation	How likely are you to fall asleep?
1. Sitting and reading	
2. Watching TV	
3. Sitting, inactive in a public place (e.g., a theater or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch without alcohol	
8. In a car, while stopped for a few minutes in traffic	

Terms and Conditions of Service
Read Carefully Before Signing

1. Consent to Medical Procedures

Patient consents to the procedures, which may be performed by Advanced Sleep Medicine Services, Inc. in connection with Patient's diagnosis or treatment.

2. Release of Information

Patient hereby authorizes Advanced Sleep Medicine Services, Inc. to furnish to Patient's insurance company all information that the said party may request concerning Patient's diagnosis or treatment. Furthermore, Patient authorizes Advanced Sleep Medicine Services, Inc. to release Patient's sleep study results and report to other caregivers for the purpose of further diagnosis or treatment.

3. Assignment of Benefits

- Your insurance company may send our payment directly to you. Although every effort is made on our part to streamline the payment process with your insurance carrier, there are times when you may receive a check for the services we provided. Should you receive payment, we are requesting that once the check has cleared your financial institution, you contact our business office at the toll free number listed below to settle your account balance. Please keep in mind the amount owed may be more than the face value of the check you receive. This will be due to any co-pays, co-insurance and/or deductibles applied to the claim. Take the time to review your explanation of benefits that accompanies the payment carefully for the total amount owed to our office. Failure to settle any unpaid balance may result in your account being forwarded to a collection agency. **INITIAL:_____**
- Patient understands that Patient is responsible for understanding his/her individual insurance policy and benefits prior to seeking services.
- Patient recognizes that Advanced Sleep Medicine Services, Inc. will bill and attempt to collect from Patient's insurance, as courtesy to Patient and that Patient is financially responsible to Advanced Sleep Medicine Services, Inc. for all charges for services rendered. Patient understands that this may lead to Patient receiving a bill, which may include any deductible, co-payment and co-insurance and agrees to pay such bill. **INITIAL:_____**
- If Patient is an HMO patient, Patient understands that Patient is responsible for any amount attributed to co-pay; deductible or non- covered services, should that apply to Patient's plan. **INITIAL:_____**

4. Automated Collections Calls

I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive autodialed, pre-recorded calls, or both, from or on behalf of Advanced Sleep Medicine Services, Inc. at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, pre-recorded calls, or both, and understand that my consent to such calls is not a condition of purchasing any goods or services. **INITIAL:_____**

5. Authorized Signature

Patient certifies that he/she has read this form, understands and agrees with it fully. If this form is signed by anyone other than Patient, then the signee certifies that he/she is Patient's legal representative or is duly authorized by Patient (as the patient's representative) to execute this form for and on behalf of patient and to accept its terms for and on behalf of Patient who shall be bound thereby.

Signature of Patient/Patient Representative: _____

Print Name of Patient/Patient Representative: _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

The rights of patient(s) include, but are not limited to the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Be given information about your rights for receiving testing and treatment.
- Receive a timely response to any reasonable requests you may make for services.
- Be given information about Advanced Sleep Medicine Services, Inc.'s policies, procedures and charges for services.
- Choose your medical providers.
- Be given appropriate and professional quality testing & treatment to you.
- Exercise your rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, the source of payment or utilization of services.
- Be free from physical and mental abuse and/or neglect.
- Be given proper identification by name and title of everyone who provides any medical services to you.
- Be given the necessary information so you will be able to give information consent for your service prior to the start of any service.
- Be given complete & current information concerning your diagnosis, treatment, risks, alternatives and prognosis as required by your physician's legal duty disclose in terms and language you can reasonably be expected to understand.
- Participate actively in decisions regarding the medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Confidential treatment of all written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home. Written authorization of the member or authorized legal representative shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except as required by law.
- Review your clinical records at your request.
- Voice your complaint with and/or comment change in medical services and/or staff without being threatened, restrained, and/or being discriminated against.
- Full consideration of privacy concerning your medical care program.
- Case discussion, consultation and treatment are confidential and should be conducted discreetly and to be advised as the reason for the presence of any individual.
- Participate in the consideration of ethical issues that arise in your care.
- Be informed of the actual dollar amount of charges, if any, for which you may be liable.
- Have access, upon request, to all bills for services you have received regardless of whether the bills are paid out-of-pocket or by another party.
- Voice a complaint and/or comment or request a change in medical services and/or staff without being threatened, restrained, and/or being discriminated against. To voice a complaint or comment, you may reach us directly by emailing info@sleepdr.com or calling (877) 775-3377 and requesting the Compliance Officer. You may also file a complaint with the credentialing body, the Joint Commission, online at www.jointcommission.org/GeneralPublic/Complaint or by email at complaint@jointcommission.org or by fax at (630) 792-5636 or by mail at Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL, 60181. After receiving a complaint, we will contact you, record information regarding your concern, ask you what actions you feel should be initiated, attempt to resolve the complaint to your satisfaction, and report the status back to you within five business days of receiving your communication.

The responsibilities of patient(s) include, but are not limited to the responsibility to:

- Give accurate and complete health information concerning your past illnesses, hospitalization, medication, allergies, and other pertinent items.
- Assist in developing and maintaining a safe and cooperative environment for care & services to be provided
- Refrain from inappropriate behavior during the procedure, including but not limited to any sexual behavior or aggressive behavior.
- Inform Advanced Sleep Medicine Services, Inc. when you will not be able to keep your appointment.
- Participate in the development and update of your treatment plan.
- Follow direction in regards to your testing and treatment.
- Request further information regarding anything you do not understand.
- Contact your physician whenever you notice any unusual feelings or sensations during your plan of service/treatment.
- Contact your physician whenever you notice any change in your condition.
- Give information regarding any concerns and problems you may have to an Advanced Sleep Medicine Services, Inc. staff member.
- Contact Advanced Sleep Medicine Services, Inc. prior to any change of telephone number or address.
- Patient agrees to meet all his/her financial obligations and responsibilities agreed upon with the organization.

Patient Signature:_____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Advanced Sleep Medicine Services, Inc.'s Notice of Privacy Practices and HIPAA policy with the effective date of April 14, 2003. Notice is also available on the website at www.sleepdr.com/HIPAA. I will notify Advanced Sleep Medicine Services, Inc. of any special requests that I may have with regards to my private health information.

_____
Signature of Patient/Patient Representative

_____
Print Name of Patient/Patient Representative

_____
Relationship to Patient

_____
Date

HST Device Patient Liability Form

I, _____, agree to return the equipment to the Advanced Sleep Medicine Services, Inc. facility located at : _____ *(Facility address)* on _____ *(Return date).*

I acknowledge that failure to return the HST device within **3 business days** of the return date serves as authorization for the Advanced Sleep Medicine Services, Inc. representative to bill me in the amount of $3,500.00 for the purchase of the device.

Device Tag: _____

Print Name: _____

Signature: _____

Date: _____

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Home Sleep Test (HST)

ORIENTATION/SETUP CHECKLIST

Patient Name:
DOB:
Referring Physician:
Phone Number:

Patient understands by re-demonstration the information below:

	Power Switch		Equipment to be used during sleep
	Reviewed the "test complete" light indicator		Reviewed how to respond to error notifications
	Instruction Manual Reviewed		Reviewed troubleshooting procedures
	Reviewed patient's rights & responsibilities		Signed Summary & Receipt of Privacy Notice
	Completed Pre-study Paperwork		Signed Patient Liability Form

Comments: _____

_____

Patient/Caregiver Signature **Date**

Advanced Sleep Medicine Services, Inc. Clinician **Date**