



## ***In-Center Sleep Study CHECKLIST***

Please place a check mark next to each item.

Completed by Patient	Verified by Technician	
<input type="checkbox"/>	<input type="checkbox"/>	<b>In-Center Sleep Study Instructions (Page 1)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Patient Information (Page 2)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Epworth Sleepiness Scale (Page 3)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Patient Medical Conditions</b> (including medications list, if needed) (Page 4)
<input type="checkbox"/>	<input type="checkbox"/>	<b>Patient Pre-Study Questionnaire (Page 5)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Terms and Conditions of Service (Page 6)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Patient Rights and Responsibilities (Page 7)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Acknowledgement of Receipt of Privacy Practices (Page 8)</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Consent to Polysomnography (Page 9)</b>

  

Provided by Patient	Received by Technician	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Primary &amp; Secondary Insurance Cards</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Driver's License or Photo ID</b> (or parent's for patients under 18 years old)
<input type="checkbox"/>	<input type="checkbox"/>	<b>Copay or Deductible</b>

**Attention technician: Scan the originals into the patient account and give the original paperwork to the patient to take home.**

Technician Signature: \_\_\_\_\_



## Sleep Study Instructions

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1. 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.
2. Please contact your referring physician in 7-10 business days for your results and recommendations.
3. 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.

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Patient/Caregiver Signature

Relationship to Patient

Date



**Advanced Sleep Medicine Services, Inc.**  
**The Sleep Experts®**

**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: \_\_\_\_\_

**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	



### Patient Medical Conditions

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck Size: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

	YES	NO
1. Do you snore?		
2. Do you wake up gasping for air?		
3. Has your bed-partner witnessed apneas/cessation in breathing?		
4. Do you grind your teeth in your sleep?		
5. Do you talk in your sleep?		
6. Do you sleep walk?		
7. Do you have trouble falling asleep?		
8. Do you have trouble staying asleep?		
9. Do you feel sleepy during the day?		
10. Do your legs twitch or jerk in your sleep?		
11. Do you sleep on your back?		
12. Do you smoke? If yes, how much?		
13. Do you have a pain condition?		
If yes, please explain: Please rate your pain on a scale of 1 to 10 (circle one): 1 2 3 4 5 6 7 8 9 10		
14. Do you use oxygen at night?		
If yes, how much?		
15. Do you have any medical conditions?		
If yes, please list here:		
16. Have you ever had a sleep study before?		
If yes, what was the outcome? Were you diagnosed with obstructive sleep apnea? Were you prescribed a PAP device? Are you using CPAP, BiPAP or another device? What type? What pressure setting?		
17. Do you take any medications? (use back of sheet if needed)		
Type of Medication	Reason for Medication	Dosage Time of Dosage/Last Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		



## **Patient Pre-Study Questionnaire**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Date: \_\_\_\_\_

	YES	NO
<b>1. Have you had any beverages containing caffeine today?</b>		
If yes, please specify what and when:		
<b>2. Have you had any alcoholic beverages today/tonight?</b>		
If yes, please specify what and when:		
<b>3. Do you normally drink alcohol?</b>		
If yes, how much?		
<b>4. Compared to the usual, did you get the same sleep last night?</b>		
If no, please explain:		
<b>5. Have you felt tired today/tonight?</b>		
<b>6. Did you take any naps today/tonight?</b>		
<b>6. Do you usually take naps?</b>		
<b>7. Has anything unusual happened to you today?</b>		
If yes, please explain:		
<b>8. Did you eat dinner tonight?</b>		
If yes, at what time?		
<b>9. How did you sleep last night?</b>		
<b>10. At what time did you go to bed?</b>		
<b>11. At what time did you awaken?</b>		
<b>12. What is the reason you are having this sleep study?</b>		



## ***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: \_\_\_\_\_



## Advanced Sleep Medicine Services, Inc. The Sleep Experts®

### **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](mailto: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](http://www.jointcommission.org/GeneralPublic/Complaint) or by email at [complaint@jointcommission.org](mailto: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: \_\_\_\_\_





Advanced Sleep Medicine Services, Inc.  
The Sleep Experts®

**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](http://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



**CONSENT FOR POLYSOMNOGRAPHY**

I understand that I will be undergoing a sleep study by Advanced Sleep Medicine Services, Inc. Electrodes and other sensors will be attached to my head and body at previously determined sites. There may be a brief unpleasant odor from the adhesive, topical gel and other products used. The preparation needed to obtain contact and produce clear signals through the electrodes requires light abrasive scrubbing, known to cause redness, temporary irritation and occasionally skin or eye infection. The tape used to hold the equipment in place may cause discomfort during removal. Standard face lotion is available for the redness if requested.

I understand that during my study, CPAP or BIPAP devices may be used to assist my breathing. Additionally, the air may cause a temporary bloating, also known as aerophagia (a condition that occurs when a person swallows too much air, which goes to the stomach, causing temporary abdominal pain, bloating and frequent belching). During the study, I will be free to roll over in bed, but will have to ask for assistance to get out of bed. I will be monitored visually for my safety throughout the night.

I understand the reason for the test and the procedure has been explained to me. I release Advanced Sleep Medicine Services, Inc. and all of its employees of all liability.

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Signature of Patient/Patient Representative

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Print Name of Patient/Patient Representative

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Relationship to Patient

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Date