Roseville Pulmonary and Sleep Medicine Clinic

PATIENT SLEEP QUESTIONNAIRE

Date: _____

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

Home Address: _____ City: _____ Zip: _____

Best Phone Number: _____ Email: _____

Referring Doctor: _____ Primary Doctor: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Our doctors and office staff need to know who we are allowed to speak with if you are unavailable.

Name: _____ Phone Number: _____ Relationship: _____

Normal Bedtime: _____ Normal Wake Time: _____
How long does it take for you to fall asleep: _____

Have you had a prior sleep study: Yes ☐ No ☐ If yes: Home Study ☐ In-lab Study ☐

Do you have a history of or are currently experiencing:

Yes ☐ No ☐ Daytime Sleepiness/Fatigue
Yes ☐ No ☐ Loud/Irregular snoring
Yes ☐ No ☐ Witnessed apnea (stop breathing)
Yes ☐ No ☐ High blood pressure

Epworth Sleepiness Scale

How likely are you to doze/fall asleep during the following states?

0 = Would never doze or sleep
1 = Slight chance of dozing or sleeping
2 = Moderate chance of dozing or sleeping
3 = High chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
WHILE SITTING AND READING	0 1 2 3
WHILE WATCHING TV	0 1 2 3
SITTING INACTIVE IN A PUBLIC PLACE (CHURCH, DOCTOR'S OFFICE, ETC.)	0 1 2 3
AS A PASSENGER IN A CAR FOR ONE HOUR OR MORE WITHOUT A BREAK	0 1 2 3
LAYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	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, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0 1 2 3
	Total: _____

Roseville Pulmonary and Sleep Medicine Clinic

Insurance and Financial Policy

The Sleep Center is committed to providing you with the best service possible. If you have medical insurance, we will help you receive the maximum benefit available to you. To achieve this goal, we need your assistance and your understanding of our financial policy.

We will attempt to assist you with insurance questions, but you should be aware of the following:

1. Your insurance is a contract between you, your employer, and your insurance carrier. We are not a party to that contract.
2. Not all services are considered "COVERED SERVICES" by every insurance carrier. Insurance carriers select which services they will or will not cover. We suggest that you read your individual contract carefully and if you have questions, contact your carrier directly.
3. Our fees are considered to be within the acceptable range by most insurance carriers. Generally, insurance carriers pay a percentage (such as 70% or 80%) of the "usual and customary" charges for this region.
4. If your insurance carrier requires a referral from your doctor or and authorization from the insurance carrier, it is important to understand that you are responsible for obtaining such referral or authorization prior to the commencement of your consultation.
5. In accordance with Federal Statutes and the State Balance Billing Law, the Sleep Center must balance bills for all outstanding charges. Therefore, after your insurance claim is filed, and either payment is received or the claim is denied, you will be billed for the remaining balance, if any, by mailed statement. In the event that we receive no response from your insurance carrier, you will be billed for the full amount. Payment for services is due at the time you receive your statement.
6. **You agree to supply us with ALL CURRENT INSURANCE information. If we do not have a copy of your current card or have not been provided with ALL INSURANCE information, you accept full financial responsibility.**

_____
Initial and Date

We must emphasize that our relationship is with you and not your insurance carrier. We file insurance claims, but all charges are your responsibility from the date of services rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for assistance in the management of you account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please contact your carrier.

I have read all information above and understand fully:

_____ _____ _____
Print Name Signature Date

_____
Patient Date of Birth

_____
Witnessed Office Staff Signature

Revised 11.2023

Roseville Pulmonary and Sleep Medicine Clinic

Notice of Privacy Practices

This notice describes how medical and personal information about patients may be used and disclosed, and physicians and/or patients can get access to this information.

Roseville Pulmonary and Sleep Medicine Clinic is required to maintain the privacy of patients' protected health information (PHI) in accordance with federal and state statues, rules, standards and regulations. Patients have the right to:

- Request restrictions on the use and disclosure of their PHI
- Receive confidential communications concerning their medical condition and treatment.
- Inspect and copy their PHI
- Amend and submit corrections to their PHI
- Receive and accounting of how and to whom their PHI had been disclosed.

Uses and Disclosure of PHI:

Payment: PHI may be used to seek payment from health plans from other sources of coverage such as an automobile insurer, or from credit card companies that a patient may use to pay for services. For example, a patient's health plan may request and receive information on dates of service, the services provided, and the indicated medical condition.

Findings/Reports: PHI may be released to physicians and their staff member. For example, the results of a sleep test will be available to physicians, and their staff (nurses, clerical & billing staff). Patients should request information regarding test results directly from their ordering referring physician.

Health Care Operations: PHI may be used as necessary to support the day-to-day activities, and management of the Sleep Clinic for example, information on the services provided may be used to support budgeting and financial reporting and activities, and to evaluate and promote quality.

Law Enforcement: PHI may be disclosed to law-enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: PHI may be disclosed to the public health agencies as required by law. Other uses and disclosures of PHI will be referred to patients' ordering or referring physicians.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and fully understand the consents above.

Name of Patient (print): _____

Patient Date of Birth: _____

Signature of Patient: _____

Date Signed: _____

Consent of legal guardian, patient advocate of nearest relative if patient is unable to sign or is a minor.

Print Name of Guardian, Patient Advocate or Nearest Relative: _____

Signature of Guardian, Patient Advocate or Nearest Relative: _____

Date Signed: _____

Relationship to Patient: _____