Sleep Medicine Institute OF TEXAS, PA

PATIENT REGISTRATION FORM

Patient Last Name: _____First Name: _____Date:_____

Address _____City_____State_____Zip_____

Date of birth_____ Gender _____Social Security #_____Marital Status: _____

Home phone _____Cell Phone _____Preferred Phone_____

Email address (required) _____

Primary care doctor Name_____City_____State_____

Referring doctor Name_____City_____State_____

Employer Name _____City_____State_____

Emergency contact name _____Date of birth_____

Emergency contact phone_____Relationship_____

Ethnicity: Hispanic or Latino / not Hispanic or Latino /prefer not to answer **Language:** English /Spanish / other
Race: American Indian /Asian /African-American /Caucasian / Hawaiian /Pacific Islander /Unknown

How did you find us? Internet search / Facebook / Website / doctor / family / friend / Radio / TV / Billboard

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Primary insurance Carrier

Company name_____ID:_____Group#_____

Subscriber Name _____Birthdate_____Relationship_____

Secondary Insurance Carrier

Company name_____ID:_____Group#_____

Subscriber Name _____Birthdate _____Relationship_____

I voluntarily consent to medical treatment at Sleep Medicine Institute of Texas. I authorize the holder of medical or other information to release to my insurance carrier any information needed for this or related insurance claim. I agree to pay any charges incurred by me to Sleep Medicine Institute of Texas.

_____ _____

Patient Signature/Guardian if patient is minor **Date**

A VALID PHOTO ID AND INSURANCE CARD(S) ARE REQUIRED AT CHECK IN

Sleep Medicine Institute OF TEXAS, PA

FINANCIAL POLICIES

PLEAES READ THE ENTIRE DOCUMENT AND LET OUR STAFF KNOW IF YOU HAVE ANY QUESTIONS.

The policies outlined below are established to avoid any misunderstandings and to allow for a proper understanding of patient responsibilities.

- It is patient's responsibility to provide Sleep Medicine Institute of Texas with your current health insurance, your primary and secondary health insurance and any change or termination of your health insurance coverage and to bring your insurance card(s) at each visit.
- It is the patient's responsibility to provide Sleep Medicine Institute of Texas with any change in demographic information.
- It is the patient's responsibility to pay any copay, deductible or co-insurance at the time of visit. Certain services such as sleep studies and PAP machines require pre-service payments.
- Any medical service not covered by the patient's insurance plan are the patient's responsibility and payment in full is due at the time of service.
- It is the patient's responsibility to ensure that proper referrals are provided to our office as needed by the patient's insurance company. If a valid and current referral from your primary care physician is not on file at the time of visit the appointment will be rescheduled or the patient may be responsible for the charges due to lack of referral.
- The patient or guarantor on the account will be billed for any patient due balances after patient's health insurance has paid. Upon request an itemized statement will be provided in 10 business days.
- If there is an overpayment on the patient's account a refund will be issued to the patient in the same method that the payment was made.
- For a patient who is a minor, the adult responsible for payment will be required to make the payments due at the time of the visit.
- Returned checks: There will be a $25 service charge for checks returned for insufficient funds.
- Payments can be made with all major credit cards, checks and cash.
- Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

I understand the above information and agree to be responsible for the patient below:

Patient Name _____ Date of birth_____

Signature of patient /responsible party _____Date_____

Sleep Medicine Institute OF TEXAS, PA

GENERAL POLICIES

The following information about our practice will give you a better understanding of the various procedures within out practice. If you have any questions please do not hesitate to ask our staff. Thank you!

- **Appointments:** At each appointment you will be asked to confirm your demographic and insurance information. Please arrive prior to your appointment time with your photo ID and insurance card(s). Patients arriving more than 15 mins late or New patients arriving without a valid photo ID may have to be rescheduled.

- **Appointment cancellations / No-shows:** We understand unexpected things happen. Appointments are in high demand and it is very important that you keep your appointment time. If you are unable to keep your appointment, please call our office and let us know 24 hours in advance so that we may open that slot for another patient. Without prior advance notice to the office you will be charged a $25 fee for clinic visits, $100 for missed Sleep studies and sleep studies cancelled within 24 hours. For Durable Medical Equipment supplies, there is a $40 re-stocking fee if the supplies are not picked up within 5 business days.

- **Assignment of benefits:** I do hereby assign payment directly to Sleep Medicine Institute of Texas for medical benefits for professional services rendered. I understand that I am financially responsible for any charges not covered by my insurance. I also authorize the release of information as may be necessary for purpose of treatment, payment and operations such as credentialing, peer review, accreditation and compliance with state and federal laws.

- **Insurance referrals to see a specialist:** It is your responsibility to make sure that Dr. R. V. Ghuge and Sleep Medicine Institute of Texas is in your insurance network before making an appointment. If your health insurance requires a referral, it is your responsibility to obtain a referral prior to any service at Sleep Medicine Institute of Texas. Failure to obtain a referral will cause your insurance benefits being paid at a reduced rate or not paid at all. You, the patient, would then be responsible for the amount not paid by insurance.

- **Prescription Refills:** Please do not wait till you run out of medication to get a refill. Contact your pharmacy for all prescription refills 72 hours in advance of needing a refill. Please be aware no refill requests will be completed after hours, on holidays or over the weekend. Certain controlled substances will only be refilled during regular business hours. Please allow two business days to process a medication refill.

- **Pre-authorizations for medications, sleep studies and other procedures**: Recently several medications, sleep studies, oral appliances and Pap devices require a pre-authorization from the health insurance company before the medication or the service can be rendered. The process of obtaining a pre-authorization from the insurance company is a complicated process that may require 1-15 business days depending on the insurance company, its medical guidelines and policies, denial of the pre-authorization request and its appeal, and various factors that are out of our control. Please allow at least five business days if your insurance requires a prior authorization for a medication. You may be charged $35 in advance for staff obtaining a prior authorization.

Patient signature: _____ Date_____

GENERAL POLICIES CONTINUED

- **Phone calls**: Please feel free to leave a message with your request and be sure to include your name and date of birth. All calls will be returned within 24 working hours.

- **Medical Staff:** Sleep Medicine Institute of Texas has on staff Nurse Practitioners who assist in the delivery of medical care. A Nurse practitioner is a graduate of a certified training program including eight years of RN. BSN and MSN and is licensed by the state board. Under the supervision of the physician, the Nurse Practitioner can diagnose, treat and monitor common acute, chronic conditions and provide maintenance care. "Supervision" does not require the physical presence of the supervising physician but rather overseeing the activities of and accepting responsibility for the medical services provided.

- **Medical Records fee:** According to the Medical Records Release and Charges, Texas Administrative Code. Title 22, Part 9, Chapter 165, Section 65.2, Base medical records copy charges re $25 for the first twenty (20) pages, and $0.50 per page for every copy thereafter. Postage is additional and payment is required in advance. Sleep Medicine Institute of Texas will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed the form authorizing records 'release. Medical Record does not include billing records.

- **E-MAIL AND PATIENT PORTAL OPT-IN AGREEMENT:** I acknowledge Sleep Medicine Institute of Texas has requested I register with the Patient Portal as a means of greater access and efficient communication. I understand this is a secure means of electronic communication that requires a password and email address to facilitate an exchange of information. I understand any electronic communication may contain personal information relating to my medical care. It is my responsibility to safeguard my password to the Patient Portal. An appointment reminder system will send an email to you with information regarding your office visit. Studies show that more than 70% of patients say reminders help them remember an appointment. Place your initials below to Opt-In and indicate that you would like to be included in this program.

I hereby give consent to confidential and clinical information being e-mailed to me or left on my voicemail including appointment reminders, referrals, billing and insurance information. **Opt in / Opt out (please circle one)**

I have read and understand the practice's general policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Print Name of patient Date of Birth

_____ _____

Signature of Patient/Guardian Date

Sleep Medicine Institute OF TEXAS, PA

Authorization for Release of Protected Health Information

Patient Last Name: _____First Name: _____DOB: _____

I understand that it is the policy of Sleep Medicine Institute of Texas, PA to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company (-ies) for payment of my claim, I would like for the following person/people to have access to my Private Health Information.

Name	Date of Birth	Clinical Information	Financial Information	Restricted Information

ACCESS TO RESTRICTED INFORMATION

If you do not wish to share specific clinical information with any of the persons listed above please specify what clinical information you **DO NOT WISH** to share:

___Sexually transmitted diseases ___Terminal Illness ___Mental/behavioral health ___Pregnancy

_____ _____

Patient/ Guardian signature Date

_____ _____

Staff/ Witness signature Date

Sleep Medicine Institute OF TEXAS, PA

MEDICATIONS

Patient Last Name: _____First Name: _____DOB: _____

Local Pharmacy Name: _____ Phone # _____

Address: _____ City: _____State: ___Zip: _____

Mail Order Pharmacy Name: _____

Are you allergic to any medication? Yes/no

Name the medications you are allergic to: _____

MEDICATION NAME	STRENGTH	DIRECTIONS

_____ _____

Reviewed by Date

Sleep Medicine Institute OF TEXAS, PA

Epworth Sleepiness Scale (ESS) Date_____

Patient Last Name: _____First Name: _____DOB: _____

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

What are the chances of you feeling sleepy in the following situations?

Situations	Unlikely 0	Mild 1	Moderate 2	High 3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in public places	0	1	2	3
As a passenger in a car for 1 hour without a break	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Laying down in the afternoon to rest, if circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch with no alcohol intake	0	1	2	3

GSS Score_____

Ghuge Fatigue Score (GFS)

How many hours in the day do you feel tired?

- Less than 2 hrs / 2-4 hrs / 4-6 hrs / 6-8 hrs / more than 8 hrs

What is the intensity of your fatigue? (0 is Minimum to 5 is maximum) 0 1 2 3 4 5

How long have you experienced Fatigue?

- Less than a week / 1 week – 1 month / 1 month – 6 months / 6 months – 1 year / more than 1 year

Does your fatigue interfere with your lifestyle? Yes / No

Does your fatigue interfere with your work? Yes / No

GFS Score: _____ Reviewed by: _____ Date: _____

Sleep Medicine Institute OF TEXAS, PA

PATIENT HEALTH INFORMATION

REASON FOR VISIT (list all your chief complaints here):

_____

_____

_____

Past Medical History: List any medical condition you were treated for in the past:

_____

_____

_____

List any surgeries you have had (include dates):

_____

_____

_____

_____

Past tests (include dates)

TEST	DATES	YEAR	DATES	TEST	DATES
Colonoscopy		Stress test		Home sleep study	
Endoscopy		Mammography		In lab sleep study	
Echocardiography		Bronchoscopy		OTHER:	

List other surgeries / tests here:

_____

_____

Previous Sleep Disorder history:

Type of sleep study done: *Please mark all that apply*

- Home sleep apnea test / In-lab diagnostic sleep study / In-lab Titration sleep study / do not know
- Type of PAP device previously prescribed
    - CPAP / BiPAP / BiPAP with ST mode / BiPAP with ST mode with backup rate / do not know
    - Type of mask used: _____

Past experience with PAP device:

_____

Reviewed by: _____ Date: _____

Sleep Medicine Institute OF TEXAS, PA

Sleep History and History of Social Habits Date: _____

Patient Last Name: _____First Name: _____DOB: _____

Please circle the appropriate symptoms you have experienced or your spouse /significant other have witnessed:

Snoring:	**Weight:**
Mild / Moderate / Loud / Very Loud Duration of snoring:_____ Progression: has worsened / has improved Accompanied with stopped breathing: Yes / No	Steady weight : Yes / No Current weight _____lbs Weight gain of _____lbs in _____yrs Weight loss of _____ lbs in _____yrs
Apnea:	**Insomnia and sleep quality:**
Snort in sleep / Gasp while asleep / Choke while asleep Sleep in separate bedrooms: Yes / No Witnessed apnea /stopped breathing: Yes / No Dry mouth/sore throat in the morning: Yes / No Headaches: Morning / During the day or night: Yes / No Apnea with acid reflux: Yes/No Wake yourself up through the night: Yes / No If yes, how many times do you wake up at night_____	Bed time:_____Wake-up time:_____ Time it takes to fall asleep:_____ Estimated total amount of sleep:_____ Number of awakenings through the night:_____ Wake up with racing hear / gasping / urination / pain/muscle cramps Wake up feeling groggy/sleepy/tired/unrefreshed/ alert/energized Sleep quality is light/sound/variable
Nasal symptoms:	**Dreams and paralysis:**
Nasal congestion or obstruction: Day/Night/All the time Nasal allergies: Yes / No Use nasal or oral decongestants or allergy medications: Yes / No Nasal spray type: Saline/Steroid/ Astelin / Astepro /Afrin Nasal drip or drainage: Yes / No	Paralysis with anger/laughter/excitement/during start or end of sleep or during a nap: Yes/No Dreams while awake: Yes/No Vivid dreams / hallucinations during naps or during sleep: Yes/No Dreams associated with anxiety/violence: Yes/No Enactment of dreams: Yes/No
Limbs:	**Headache:**
Restless arms or legs: Yes / No More in the morning /evening / night Relieved with movement: Yes / No	Starts in morning/afternoon/evening/night Headache lasts for _____ hours
Coffee with caffeine: _____cups per day Do you use caffeine to stay awake during the day? Yes / No Decaffeinated Coffee: _____cups per day Tobacco: _____per day Cigars/cigarettes: _____per day	**Tea**: _____cups per day Caffeinated soda: _____per day Alcohol: _____drinks per day Recreational Drugs: Yes / No

Reviewed By: _____ Date_____

Sleep Medicine Institute OF TEXAS, PA

Review of Systems

Date: _____

Patient Last Name: _____First Name: _____DOB: _____

Check all that apply:

GENERAL	Emphysema	**PSYCOLOGICAL**
Anorexia	Wheezing	Anxiety / ADD / ADHD
Excessive daytime sleepiness	Waking up from sleep with:	Claustrophobia
Fatigue	• Wheezing	Change in sleep pattern
Headaches	• Shortness of breath	Depression
Weight problems	**GASTROINTESTINAL**	Disorientation
Weight loss	Abdominal pain	Early Awakening from sleep
EYES	Colitis	Easily irritated
Blurred Vision/ double vision	Difficulty Swallowing	Fearful
Decreased Night Vision	Gastric reflux	Frequent crying
Double vision	**FEMALE GENITOURINARY**	Hallucinations
Eye redness	Excessive urination at night	Impaired cognitive functions
Puffiness around eyes	Menstrual irregularities	Inability to concentrate
Visual disturbance with headache	**MALE GENITOURINARY**	Insomnia
EARS, NOSE THROAT, MOUTH	Change in urinary stream	Migraines
Decreased taste / sense of smell	Difficulty with erection	Memory Loss
Deviated Nasal septum	Excessive urination at night	Mood changes
Earache/ ear discharge	**MUSCULOSKELETAL:**	Panic attacks
Hearing loss	Back pain or joint pains	Suicidal thoughts
Hoarseness	Leg cramps	Suicidal planning
Mouth breathing	Leg weakness	**ENDORCINE**
Nasal Congestion	Muscle cramps or muscle pain	Diabetes
Nose bleeds	Swelling of legs	Thyroid Problems
Oral Ulcers	**SKIN**	**HEMATOLOGY/ LYMPHATIC**
Ringing in the ears (tinnitus)	Brittle Nails	Anemia
Runny nose	Coarse Hair/ coarse skin	Bleeding disorder
Neck stiffness / pain / swelling	Dryness of skin	Swollen lymph notes
Sore throat	Hair loss / hair growth	Blood cancers
CARDIOVASCULAR	Hives	**ALLERGIC/ IMMUNOLOGIC**
Cold cramps	Skin Rash	Immune deficiencies
Chest pain	Skin Color changes	Allergic conditions
Difficulty breathing lying down	**NEUROLOGICAL**	**CANCERS (List below include date)**
Heart stent	Decreased memory	
Hypertension	Dizziness	
Irregular heart beat	Numbness of hands/feet	
Heart Murmur	Parkinson's disease	**OTHER (List below)**
Palpitations	Seizures	
RESPIRATORY	Stoke	
Asthma	Tremors	
Chronic cough	Fibromyalgia	
Decreased exercise tolerance	Tumor in Brain	

Reviewed by: _____ Date: _____