Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701
Ph: 903-787-7533;
Fax:903-787-8825

Child Registration Form

Patient Last Name: _____First Name: _____DOB: _____Sex: _____

Address: _____City: _____State: _____Zip:_____

Home Phone: _____Cell Phone: _____Parent/Guardian Phone: _____

E-mail address *(required)*:_____Social Security Number: _____

Primary Care Physician Name: _____City: _____State:_____

Referring Physician Name: _____City: _____State: _____

Emergency Contact Name: _____Date of Birth: _____Sex:_____

Emergency Contact Phone number: _____Relationship to Patient: _____

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 / Refuse to answer

How did you find Sleep Medicine Institute of Texas? (Check all that apply)
TV ad / Radio/ Website / Facebook / Billboard / Primary care physician or dentist / family and friends

Primary Insurance Information:

Insurance carrier Name: _____ID:_____Group:_____

Subscriber Name: _____Date of Birth: _____Relationship:_____

Secondary Insurance Information:

Insurance carrier Name: _____ID:_____Group:_____

Subscriber Name: _____Date of Birth: _____Relationship:_____

Medical Consent: I voluntarily consent to medical treatment at Sleep Medicine Institute of Texas

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.

Sleep Medicine Institute of Texas has on staff Nurse Practitioners who assists 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. I have read the above and hereby consent to the services of nurse practitioner for my health care needs as and when needed. I understand that at any time I can refuse to see the Nurse Practitioner and request to see the physician.

By signing below I am verifying the personal data on this sheet is accurate and indicating I understand the information provided.

Patient/guardian Signature:_____ **Date**: _____

A valid photo ID is required for the patient (if applicable) and/or the parent/guardian.

Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701

Ph: 903-787-7533;

Fax:903-787-8825

Financial Policy

Patient Last Name: _____First Name: _____DOB: _____

Thank you for choosing Sleep Medicine Institute of Texas, PA as your provider. We are committed to your treatment being successful. Please read the following financial policy and let us know if you have any questions as we would like you to fully understand our policy.

PAYMENTS: Payment is expected at the time of service. We will accept cash, check and all major credit cards. If you do not carry insurance, or if your health insurance has sleep medicine exclusions, or a pre-existing condition clause exclusion, payment in full is expected at the time of office visit and prior to sleep tests.

APPOINTMENTS, NO-SHOW AND CANCELLATION: 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.

NO-SHOW fee: Please be aware that there is a $25.00 no-show fee for missing the office appointment without calling to cancel/reschedule. All sleep tests are subject to $100.00 fee per sleep study appointment if you cancel or reschedule within 48 hours of your sleep study test or do not show up for the Sleep test.

TREATMENT FOR MINOR: As an adult caregiver bringing a minor patient for treatment I am responsible for payment for all services rendered at Sleep Medicine Institute of Texas.

INSURANCE AND PAYMENT FOR OFFICE SERVICES: You are required to provide the office with your health information card and ID card and update us on any changes in your healthcare plans. It is your responsibility to make sure that Dr. R. V. Ghuge and Sleep Medicine Institute of Texas is in your insurance network.

Co-pays, deductible and co-insurance amounts at the time of service: Based on your contract with your health insurance company you will be required to pay the co-pay, co-insurance, deductible and out of pocket expenses. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment due to you. Failure to pay your co-pays, deductible or co-insurance is a violation of your financial responsibility with your insurance company.

RETURNEDCHECKS: You will be required to pay by cash or money order to cover the charges along with the $25 fee.

_____I will be charged $25 if my check is returned or non-sufficient funds. I understand that if my bill is turned over for non-payment, I will be charged a collection fee of 25% of the balance due.

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 15days 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.

ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service. I have read and understand the practice's financial 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.

Name of Responsible Party: _____ Relationship to Patient: _____

Responsible Party signature: _____ Date: _____

Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701
Ph: 903-787-7533;
Fax:903-787-8825

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
____Mental/behavioral health
____Terminal Illness
____Pregnancy
____Other

COMMUNICATION: ***Please initial here*** **_____**

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.

Insurance Referrals: ***Please initial here*** _____

I am responsible for getting a referral from my Primary care physician prior to my first visit if my insurance requires a referral to see a specialist. Failure to obtain a referral will cause my insurance benefits being paid at a reduced rate or not paid at all. I would then be responsible for the amount not paid by insurance

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES:

I have received a copy of the Sleep Medicine Institute of Texas Notice of Privacy Practices. I understand that Sleep Medicine Institute of Texas has the right to change its Notice of Privacy Practices from time to time and that I may contact Sleep Medicine Institute of Texas at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient/ Guardian signature Date

_____ _____

Staff/ Witness signature Date

Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701
Ph: 903-787-7533;
Fax:903-787-8825

Children's Sleep Questionnaire

Patient Last Name: _____First Name: _____Today's Date: _____

Date of Birth: _____ Gender: _____ Height (inches)_____ Weight (pounds)_____

Patient is _____oldest of _____siblings.

Referring Doctor's Name:_____

Referring Doctor's address:_____City_____State: _____Zip_____

Was your child born prematurely? Yes / No If yes, How many weeks? _____

Has your child ever been hospitalized? Yes / No If yes where? When?_____

For what diagnosis? _____

Family History: (mark all that apply and relationship to patient)

Condition	**Relationship**
Obstructive Sleep Apnea	
Anxiety	
Depression	
High Blood pressure/ heart disease	
Hypertension	
Diabetes	
Snoring	
Insomnia	
Hypersomnia/ excessive daytime sleepiness	
Narcolepsy	
Restless Leg Syndrome	

Child's Past Medical history: *(mark all that apply)*

Attention Deficit Disorder (ADD/ADHD)	Gastroesophageal reflux disease (GERD)
Allergies	Genetic disorders
Autism	High blood pressure
Anxiety	Heart disease
Cerebral palsy	Learning disability
Chronic sinusitis	Obesity
Chronic bronchitis	Obsessive Compulsive Disorder
Depression	Obstructive sleep Apnea
Drug abuse/ dependency	Speech disorder
Delayed milestones	Sinus problems
Ear Infections	Seizures
Other:	

Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701
Ph: 903-787-7533;
Fax:903-787-8825

Child's Sleep History:

Condition	Yes / No	Condition	Yes / No
A. Breathing While Asleep: Does your child:		**B. Breathing, other: Does your child:**	
l. Snore half the time?		1. Breath mostly by mouth when awake?	
2. Always snore?/ snore loudly?		2. Have a dry mouth on waking up?	
3. Cough frequently?		3. Have frequent ear infections?	
4. Have heavy/loud breathing?		4. Have frequent colds (URI's)?	
5. Gasp for air?		5. Get ill frequently?	
6. Make choking sounds?		6. Wheeze?	
7. Sound congested?		7. Stop breathing and trying to breathe?	
8. Stop breathing but try to?		8. Breath mostly by mouth?	
C. Schedule: What time does your child:			
1. Go to sleep, if school is the next day? _____am/pm			
2. Go to sleep, if NO school, or NO pre-school? _____am/pm			
3. Awaken, if school day? _____am/pm			
4. Awaken, if NO school or pre-school? . _____am/pm			
5. How many hours does your child sleep on school nights?			
6. How many hours does your child sleep on non-school or pre-school nights?			
7. Nap weekdays?		If yes, for how long?	
8. Nap weekends?		If yes, for how long? _____	
9. Appear to be the most alert? …… morning / mid-day / afternoon / evening / night			
D. Other Sleep Problems: Does your child have:			
1. Night terrors		9. Night sweats	
2. Frightening dreams		10. Twitching of legs	
3. Bedwetting		11. Wake up during the night	
4. Head banging		How many times a night	
5. Body rocking		For how long	
6. Tooth grinding		What time of the night	
7. Sleepwalking		12. Headaches upon awakening	
8. Blood on the pillow		13. Become fearful at bedtime	
		14. Awaken in a panic	
E. Daytime sleepiness in SCHOOL AGE CHILDREN: Does your child:			**Yes / No**
1. Complain of feeling tired (wish to be inactive)?			
2. Have problems with daytime sleepiness?			
3. Has a teacher or caretaker said your child appears excessively sleepy?			

Sleep Medicine Institute OF TEXAS, PA

3187 Paluxy Dr, Tyler, TX 75701
Ph: 903-787-7533;
Fax:903-787-8825

4. Have difficulty waking up?	
5. Wake up feeling unrefreshed?	
6. Have trouble getting dressed in the mornings?	
7. Have no appetite in the morning?	
8. Seem groggy in the morning?	
9. Have difficulty going to sleep?	
F. Narcolepsy in SCHOOL AGE CHILDREN: Does your child:	**Yes / No**
1. Ever have sleep attacks, or suddenly and unexpectedly fall asleep?	
2. Become weak, especially when excited, angry or laughing?	
3. Have vivid dreams when falling asleep or taking a nap?	
4. Fall asleep at school?	
5. Fall asleep in odd situations or places?	
6. Imagine seeing things before falling asleep?	
7. Experience brief moments of paralysis?	
G. Behavioral, in SCHOOL AGE CHILDREN: Does your child	**Yes / No**
1. Have behavioral problems?	
2. Do more poorly at school than expected?	
3. Seem Hyperactive?	
4. Not listen when spoken to?	
5. Become easily distracted?	
6. Fidget or squirm excessively?	
7. Become easily upset?	
8. Seem very sensitive?	
9. Worry excessively?	
10. Seem excessively anxious?	
11. Have problems relating to children the same age?	
12. Have no close friends (who are the same age and not a family member)?	
13. Have difficulty organizing tasks and activities?	
14. Stay “on the go” or act as if “driven by a motor”?	
15. Interrupt or intrude on others (interrupt conversation or games)?	
16. Uses electronic gadgets in bed? (smart phone, e-book, smart pad etc)	
17. Sleep with pet in the bed?	
18. Listen to loud music of play video games before going to bed?	

Questionnaire completed by: _____Relationship to patient: _____