Sleep Disorders Centers of the Mid-Atlantic

Name of Parent/Guardian completing this form:

_____ **Relationship to patient:** _____

Please Print

Patient Information

Name: Last:_____ First:_____ M.I.:_____

Date of birth: _____ Gender: M F

Weight: _____ Height: _____ Age: _____

Emergency Contact: _____ Phone #: _____

Relationship to patient: _____

Address:_____

_____

Email Address: _____ Home Phone #: _____

Cell Phone #: _____ Work #: _____

Referring Physician: _____

Address: _____

Phone # : _____ Fax #: _____

Primary Care Physician (if different from referring physician): _____

Address: _____

Phone #: _____ Fax #:_____

*Please note, if your insurance company requires a uniform referral to see a specialist, it will have to come from the primary care physician. We cannot schedule an appointment until the uniform referral is on file from the Primary Care Physician.

Sleep Disorders Centers of the Mid-Atlantic

Primary Insurance Information

Policy Holder's Name: _____SS #: _____

Relationship to patient: _____Policy Holder's Date of Birth: _____

Name of Insurance Co.: _____

Member Services Phone #: _____

Member ID: _____Group #: _____

Recipient #: _____(if applicable)

Claims Mailing
Address:_____

Secondary Insurance Information

Policy Holder's Name: _____SS #: _____

Relationship to patient: _____Policy Holder's Date of Birth: _____

Name of Insurance Co.: _____

Member Services Phone #: _____

Member ID: _____Group #: _____

Recipient #: _____(if applicable)

Claims Mailing
Address:_____

Sleep Disorders Centers of the Mid-Atlantic

Financial Agreement

I understand that payment for any services not covered or denied by my insurance company (co-payment/insurance deductible, pre-existing conditions, failure to obtain prior authorization/referral. Etc.) will be my responsibility. I also understand that my insurance company may not cover certain preventative charges as spirometry, urinalysis, pulse O2, and stool hemocult testing and therefore authorize my physician to bill these charges to me instead of my insurance company. I understand that if my account is forwarded to a collection agency, I will be responsible for any and all reasonable collection fees and/or attorney fees.

Patients who have HMO Policies such as, Optimum Choice, UHC: MDIPA, Aetna HMO, Cigna HMO, etc., are required to select a primary care provider before being treated. I understand that if I have a HMO Policy and have not selected the rendering physician as my primary care, I am waiving insurance benefits and will be responsible for payment.

X _____ Date: _____

Signature of Patient Representative **(Required)**

Consent for Release of Information and Physician Reimbursement

I certify the accuracy of the patient and insurance information provided to the physician and authorize the release of any medical information necessary to process this claim. I authorize my insurance company to remit benefit payments directly to the physician.

X _____ Date: _____

Signature of Patient Representative **(Required)**

Sleep Disorders Centers of the Mid-Atlantic

Medical Records Release Consent

I, _____, hereby authorize Sleep Disorders Centers of the Mid-Atlantic to release my child's medical/psychological records to:

_____

_____

Address: _____

Phone #: _____Fax #: _____

Would you like a copy of your child's sleep study results sent to you via email? Y / N

_____

Print Name

X_____ Date: _____

Signature of Patient Representative

Video/Audio Monitoring Consent

How is my privacy protected?

Sleep studies routinely include a digital recording that enables the Sleep Center Board Certified physician to visually observe sleep positions, movements, respiration and other sleep related information. The Sleep Center id required to have your written consent to perform the sleep study with digital recording. This data is protected by the *Health Insurance Portability and Accountability Act (*HIPPA), which established national standards for the security and privacy of health data.

I, _____, herby authorize the use of digital recording surveillance while on the premises and for the purpose of medical diagnosis and written consent to perform the sleep study.

_____

Print Name

X_____ Date: _____

Signature of Patient Representative

Sleep Disorders Centers of the Mid-Atlantic

Privacy Practice

The Department of Health and Human resources, Office of Civil rights, under the Public law104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this newly revised Privacy Notice to our patients. This notice to our patients meets all current requirements as is relates to Standards of Privacy of Individually Identifiable Health Information IIHI); affecting our patients. You are urged to read this.

Our privacy notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual".

Our office will use or disclose your PHI for purposes of treatment, payment, and other healthcare purposes as required to provide you the best quality healthcare services that we offer. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access.

You, as our patient, may revoke any consent at any time and all use, disclosure, and administration of related healthcare services will be revised accordingly, with the exception of matters already in process. To revoke the consent, you will have to provide this office with a written request with your signature, date and specific instructions. Any revocation will not apply to information already used or disclosed.

You, the patient, have the access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes. If the physician agrees with the request, we are bound by law to abide to any changes.

Please sign and date below indicating that you have received the privacy notice. Thank you.

_____

Print Name

X _____ Date: _____

Signature of Patient Representative **(Required)**

Sleep Disorders Centers of the Mid-Atlantic

Cancellation Policy

Please be advised, many things go into scheduling and preparing for your sleep study. We realize that a situation might arise that could force you to reschedule, postpone, or cancel your appointment. Please understand that such changes affect not only the doctors, the sleep technologist, the sleep center, but other patients, as well.

There will be a $250 charge for any in-lab sleep study cancelled less than 48-hours prior to the date of the study. There will be a $100 charge for any office visit (consultation or follow-up with the doctor; DME setup; home study set-up; mask or troubleshooting, among others) cancelled less than 48-hours prior to the office visit date. In the case of extenuating circumstances, the fee may be waived at the doctor's discretion.

I, _____, am aware of the charges that will be billed if not cancelled at least 48-hours prior to the scheduled appointment and accept the terms of the cancellation policy.

X _____ Date: _____

Signature of Patient Representative

Sleep Disorders Centers of the Mid-Atlantic

Sleep History Questionnaire

Referring Physician: _____ Self-Referred? Y / N

Please list any previously diagnosed sleep disorders:

_____

_____

Chief Complaint: Please briefly describe your child's main sleep problem and how long they have had this problem:

A. **Medication Survey:** Please list all prescription and non-prescription medications your child is currently taking:

Medication	Reason	Dose

Allergies? _____

B. **Medical History:** Please list all past or present medical conditions and/or surgeries

Sleep Disorders Centers of the Mid-Atlantic

Grade your child's tendency to fall asleep during the following situations:
(Scale: 0 = would never sleep, 1 = slight chance of sleeping, 2 = moderate chance of sleeping, 3 = high chance of sleeping)

Epworth Sleepiness Scale

Activity	0	1	2	3
Sitting and Reading				
Watching TV				
Sitting inactive in a public place (i.e. Theater or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopped for a few minutes				

Total: _____

C. Sleep Patterns
1. What is your child's normal bedtime on a weekday? _____
2. What is your child's normal wake time on a weekday? _____
3. What is your child's normal bedtime on a weekend or holiday? _____
4. What is your child's normal wake time on a weekend or holiday? _____
5. Does your child take a nap during the day? Y / N / Sometimes
    a. If so, how long is the nap? _____
6. On average, how many hours of sleep does your child get during a 24-hour period? _____
7. Is your child ever difficult to awaken in the mornings or from a nap? Y / N / Sometimes
8. Does your child snore at night? Y / N / Sometimes
    a. If yes, please describe the loudness of snoring and how often it happens

    _____
9. Have you ever witnessed your child having difficulty or struggling to breathe during sleep? Y/ N / Sometimes
10. Does your child's chest "cave-in" or "see-saw" during sleep? Y/ N / Sometimes
11. Have you ever witnessed pauses in your child's breathing during sleep? Y/ N / Sometimes
12. Do you ever shake your child or attempt to waken them to make them resume breathing? Y/ N / Sometimes
13. How long has your child had breathing problems? _____
14. Does your child sleep in any unusual positions? (Ex. Neck hyper-extended or w/ their bottom in the air? Y/ N / Sometimes
15. Does your child have excessive body movements or body position changes throughout the night? Y/ N / Sometimes
16. Does your child complain of funny, creepy-crawly feelings in their legs before falling asleep or wants their legs rubbed? Y/ N / Sometimes

17. Does your child have nightmares? Y/ N / Sometimes
    a. If yes, how often? _____
18. Does your child walk/talk during sleep? Y/ N / Sometimes
    a. If yes, how often? _____

19. If you child is over 5 years old, does he/she wet the bed? Y/ N / Sometimes
    a. If yes, how often? _____
20. Does your child sweat heavily during sleep? Y/ N / Sometimes
21. Does your child fall asleep in school or nap after school? Y/ N / Sometimes
22. Does your child complain of feeling tired during the day? Y/ N / Sometimes
23. Does your child complain of morning headaches? Y/ N / Sometimes
24. Is your child a daytime mouth-breather? Y / N / Sometimes
25. How would you describe your child's appetite? Poor / Typical (Average) / Excessive
26. Has anyone in the family ever dies of SIDS (Sudden Infant Death Syndrome)? Y / N
27. Has your child ever had surgery on their neck or throat? Y / N
    a. If yes, please describe?

    _____
    _____
    _____
28. When was your child's last physical exam? _____
29. Was anything wrong found during the exam? Y / N
    a. If yes, please explain:

    _____
    _____
    _____
30. Remarks: If there are any other aspects of your child's sleep problem that you feel are important, please describe them in the space below.

    _____
    _____
    _____
    _____
    _____
    _____

D. Family History: Please check off any known family history of the following conditions.

	Sleep Apnea	Heavy Snoring	Narcolepsy	Insomnia	Restless Leg Syndrome	Other Sleep Disturbances
Mother						
Father						
Brother						
Sister						
Grandparents						

Sleep Disorders Centers of the Mid-Atlantic

☐ I acknowledge that by signing this document, whether by digital or traditional means, is as valid as if I signed this document in writing.

Thank you for completing the registration packet. This can be returned to us via email at fax@sdcma.com, faxed to 410-582-9301, or, dropped off at our Glen Burnie or Rockville facility. Please keep in mind, this may be required by your insurance for preauthorization. The type of sleep study provided is based on insurance approval/denial. We do not make the final determination. If you have any questions, please contact us at 410-582-9300.

SDCMA Management

SLEEP DISORDERS CENTERS of the Mid-Atlantic

Four locations in Maryland and Virginia

7671 Quarterfield Rd. Suite 201 Glen Burnie, MD 21061	2530 Riva Road LL Suite 1 Annapolis, MD 21401	2301 Research Blvd. Suite 302 Rockville, MD 20850	2235 Cedar Lane Suite 201 Vienna, VA 22182

Phone: 410-582-9300 Toll Free: 1-855-SLEEP-50 email@sdcma.com Fax: 410-582-9301, 1-888-863-6470