Sleep Disorders Centers
of the Mid-Atlantic

Patient Information

Name: Last:________________________________First:________________________________M.I.:_____

Date of birth: __________________ Gender: M / F Social Security: ______________________

Address:____

____

Email Address: ____________________________ Home Phone #: ______________________

Cell Phone #: ____________________________ Work #: ___________________________

Martial Status: Single / Married / Divorced / Widowed / Separated (Circle One)

Occupation: ________________________________ Employer: ______________________________

Employer Address: ____

Is this study needed for employment? Y / N

Emergency Contact: ___________________________________Phone #: __________________

Relationship to patient: ____

Primary Insurance Information

Policy Holder's Name: ______________________________________SS #: _________________

Relationship to patient: _________________Policy Holder's Date of Birth: ______/______/______

Name of Insurance Co.: _______________________________Providers 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.: _______________________________Phone #: ____________________

Member ID: ___________________________________Group #: ________________________

Recipient #: __________________________________(if applicable)

Claims Mailing
Address:____

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 or Patient Representative

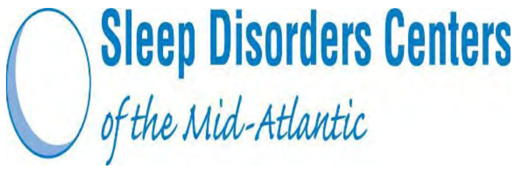
Financial Agreement

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 hemoccult 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 or Patient Representative



Medical Records Release Consent

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

____

____

Address: ____

Phone #: ______________________________________Fax #: ____________________________

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

____

Print Name

X____Date:__________________________

Signature of Patient or 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 or Patient Representative

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 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.

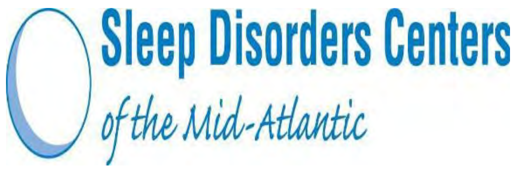
Please sign and date below indicating that you have received the privacy notice. Thank you.

____

Print Name

X____________________________________ Date:____________________

Signature of Patient or Patient Representative



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 business 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 business hours prior to the office visit date. In the case of extenuating circumstances, the fee may be waived at the SDCMA's discretion.

I, ____, am aware of the charges that will be billed if not cancelled at least 24-hours prior to the scheduled appointment and accept the terms of the cancellation policy.

X____ Date:______________________

Signature of Patient or Patient Representative

Sleep Disorders Centers of the Mid-Atlantic

Sleep History Questionnaire

Name: ____Date of Birth: _____/______/_______

Weight: ____________________Height: _________________Age: ________Sex: M / F

Referring Physician: ____Self-Referred? Y / N

Please list any previously diagnosed sleep disorders:

____

____

Chief Complaint: Please briefly describe your main sleep problem and how long you have had this problem:

A. Medication Survey: Please list all prescription and non-prescription medications you are 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

Please check if you have had any of the following:

Acid Reflux	Dizziness	Impotence
Allergies / Hay Fever	Emphysema	Muscle Aches/Cramps
Anemia	Enlarges tonsils/adenoids	Menopause
Anxiety	Fibromyalgia	Parkinson's disease
Asthma/Reactive Airway	Headaches/Migraines	Prostate Disease
Back Pain	Heart Failure / Heart Attack	Seizures
Bipolar Disorder	Head Injury or Brain Surgery	Sinusitis
Bleeding Disorder	High Blood Pressure	Stroke
Chronic Cough	Heart Murmur/Palpitations	Tuberculosis
Chest Pain	Heartburn	Thyroid Condition
		Weakness/ Paralysis

Other: ____

C. Sleep Patterns
1. On Work Days:
    1. What time do you go to bed: _________________
    2. What time do you get out of bed: ________________
    3. Usual amount of sleep you get: _______________hours
2. On Weekends/ Days Off/ Holidays
    1. What time do you go to bed: _________________
    2. What time do you get out of bed: ________________
    3. Usual amount of sleep you get: _______________hours
3. How long does it take you to fall asleep? _________________
4. Home many times do you awaken? ______________
    1. How long do the awakening last? ________________
    2. List any symptoms/reasons for awakenings:
    ____
5. Do you feel un-refreshed and sleep upon awakening? Y / N / Sometimes
6. How long does it take you to fully awaken in the morning? ______________
7. Do you wake up too early and are unable to go back to sleep? Y / N / Sometimes
8. How many hours of sleep does it take to make you feel rested? _____________hours
9. Do you have a special routine when going to bed? Y / N / Sometimes
10. What is your usual sleeping position? Back / Side / Stomach / Varies
11. Do you take medication (prescription or over-the-counter) to help you fall asleep? Y / N
    If Yes, what do you take? ______________________Dosage: __________
12. Do you have wandering thoughts or does your mind race as you are trying to fall asleep?
    Y / N / Sometimes
13. Do you sleep with a bed partner? Y / N
14. Does your sleep problem affect your bed partner? Y / N / Sometimes

D. Daytime Sleepiness

1. Are you sleepy during the day? Y / N / Sometimes
2. Has there been a recent change in your sleepiness? Y / N / Sometimes
3. Do you take naps? Y / N / Sometimes If Yes, how often? _________________
   Do you dream during these naps? Y / N / Sometimes
   Are these naps refreshing? Y / N / Sometimes
4. Have you ever experienced weakness or paralysis while laughing or angry? Y / N / Sometimes
5. Have you ever had hallucinations or dreamlike images while note actually asleep? Y / N / Sometimes
6. Do you have trouble concentrating or have difficulty remembering things? Y / N / Sometimes

Grade your 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: _________

E. Sleep & Breathing

1. Do you snore? Y / N
2. Do you snore every night? Y / N
3. Does your snoring disturb others? Y / N
4. Have you or anyone else noticed pauses in your breathing during sleep? Y / N
5. Does your sleep position affect your snoring? Y / N
6. Have you ever awakened gasping, or, short of breath? Y / N
7. Do you awaken with a dry mouth or throat? Y / N
8. Do you have morning headaches? Y / N
9. Do you breathe through your mouth while you are asleep? Y / N
10. Do you have difficulty breathing through your nose? Y / N

F. Sleep Disturbances

1. Do you experience unpleasant leg or arm sensations at bedtime? Y / N
2. Do you kick or jerk your legs during sleep? Y / N
3. Do you have pain which delays or prevents you from falling asleep? Y / N
4. Do you have frequent nightmares or vivid dreams? Y / N
5. Do you grind your teeth or have bitten your cheek during sleep? Y / N
6. Do you have pain which awakens you from sleep? Y / N
7. Have you ever walked or talked in your sleep? Y / N
8. Have you ever been unable to move for a few moments as you are awakening from sleep? Y / N
9. Have you ever had unusual movements or behaviors during sleep? Y / N
10. Have you ever wet the bed (as an adult)? Y / N
11. Have you ever fallen out of bed (as an adult)? Y / N
12. Do you get out of bed frequently to urinate? Y / N

G. Social History:

1. Do you smoke? Y / N If Yes, how much per day? ____________________
2. Have you ever smoked? Y / N If Yes, for how long? __________________How much? ______________
3. Do you drink alcohol? Y / N
4. Do you consume caffeine (soda, coffee, tea, chocolate, etc.?) Y / N If Yes, how much daily? ________

H. 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						

☐ 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