WASHINGTON SLEEP CENTER
REGISTRATION PACKET

75 Barclay Circle, Suite 220
Rochester Hills, MI 48307
Phone 586-207-1247
Fax 586-207-1264

APPOINTMENT DATE: _____ ARRIVAL TIME: _____

The Sleep Center staff looks forward to meeting you and working with you! We would like to briefly explain what to expect on the night of your sleep study.

Where: On Barclay Circle approximately ½ mile north of Auburn Road off of Rochester Road. When turning in from Rochester Road, we are located in the first building on the left immediately after the median ends, next to Chase Bank. There is parking in both the front and rear of the building. Our office is on the 2nd floor.

When: Plan to be at the center from your scheduled appointment time until 7:00 A.M. the following morning. (In most cases, early wake times can be accommodated). If you are a shift worker call the Center to arrange special sleep times.

Bring: Plan to bring your ID and insurance cards so that we can make copies. Whatever you may need to prepare for bed and for work the following morning as well as all your medications. As a matter of personal preference, you may want to bring your own pillow.

Cancelations: It is important that you understand the Sleep Center operates on a very precise schedule. We have specially trained technologists scheduled to work with you. We ask if you find it necessary to change or cancel your test, that you give us at least a 48-hour notice. **(If you fail to notify within 48 hours, you will be charged an administration fee for the missed appointment)**. If you contract a significant head cold within 5 days of your study, notify us immediately.

Questions: If you have any questions, feel free to contact a member of the Sleep Center

Day Time Hours	9:00 AM – 5:00 PM	586-207-1247
Night Time Hours	7:30 PM – 7:00 AM	586-207-1247

Important instructions and answers to frequently asked questions can be found in the "YOUR STAY AT THE WASHINGTON SLEEP CENTER" section. You are welcome to visit the center prior to your visit.

Enclosed in your packet: Patient Registration, Sleep Questionnaire, and Medication List. Please complete all paperwork and bring it with you to your scheduled appointment.

WASHINTON SLEEP CENTER

YOUR STAY AT THE WASHINGTON SLEEP CENTER

How long will my sleep study last?
A typical sleep study will last approximately 12 hours, depending on the nature of your problem and our initial findings during the sleep study.

What should I bring to the Sleep Center?
Bring your nightclothes and personal toiletries, such as robe, pajamas, slippers, toothbrush, shampoo, shaving cream, razor, etc. It is recommended that women bring two-piece night clothes as this simplifies the application of some electrodes. There may be times during your stay when you will have free time available to you. Please bring something to do during those times. A TV and magazines are available for your use, but you may also want to bring your own reading material, playing cards, crafts, handiwork, etc. If you wish to bring your own midnight snack and drink, there is a refrigerator and a microwave available at the sleep center.

If you have a cell phone, we ask that it is turned off prior to bedtime.

If you are currently taking medications prescribed by your doctor, please bring them with you and take them on your regularly prescribed schedule.

For current CPAP users, please bring your CPAP mask with you to the Center. There is no need to bring the CPAP machine itself.

Is there anything I should <u>not</u> bring to the Sleep Center?
Please do not bring any job-related work with you. Also, please do not bring any valuables or large sums of money with you, as we do not have facilities for guarding your valuables.

Are there things I should do before coming to the Sleep Center?
There are several things you can do to help insure that we will obtain the best recordings possible. The electrodes must be applied to skin that is as clean and dry as possible. Please bathe or shower before coming to the Sleep Center. Do not use any cream rinse, hair relaxer, or styling products on your hair after washing. Also, do not use skin lotion or creams on your skin before your sleep study.

Women should remove all makeup before or shortly after arriving at the Sleep Center. Men without beards should be clean-shaven before coming in for their sleep study. Men with grown beards need not shave.

PLEASE DO NOT HAVE ANY ALCOHOL OR CAFFEINE AFTER 12:00 NOON ON THE DAY OF YOUR SLEEP STUDY. While in the Center, you will be on a caffeine-restricted diet until your study is completed.

What time should I come in for my sleep study?
Please report to the sleep lab at your scheduled appointment time. Please eat dinner before coming.

What will happen after I arrive at the Sleep Center?
Shortly after you arrive, you will be asked to change into your nightclothes. The technician will begin applying electrodes to your face, head, and legs. The application of the electrodes is painless. The electrodes are attached with tape or paste. There are approximately 25 electrodes to be applied, and it takes approximately one hour to complete this procedure. These electrodes simply sense electrical activity

present in your body and conduct that information to our recoding equipment. After your hookup is complete, you can relax until your bedtime, which is usually between 10:00 and 11:00 P.M.

What happens at bedtime?
Just before your bedtime, the technician will apply a few additional sensing devices. Again, these are painless and will not restrict your movement during sleep.

There will be a technician in the monitoring room (adjacent to the bedroom) all night. If you need anything during the night, all you need to do is speak, and the technician will hear you through the intercom.

All patients are expected to stay in bed for 7 hours. The technician will wake you when the test is over. If you need to be awakened at a certain time, or need to leave the sleep lab by a certain time, please notify the technician immediately upon arrival, so that your bedtime can be adjusted accordingly.

In the morning, your electrodes will be removed and you will be allowed the opportunity to wash up/shower and get dressed to leave. Towels will be provided.

IF YOU HAVE ANY QUESTIONS OR PROBLEMS DURING YOUR STAY IN THE SLEEP CENTER, PLEASE FEEL FREE TO DISCUSS THESE CONCERNS WITH THE TECHNICIAN RESPONSIBLE FOR YOUR CARE.

PATIENT REGISTRATION

Welcome to our clinic. In order to serve you properly, we will need the following information. (**Please Print**)
All information will be strictly confidential.

Patient Name	Sex ☐ M ☐ F	Date of Birth	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address City State Zip	Primary Phone	Patient SSN

Person Financially Responsible for this Account ☐ Self ☐ Other, name and relationship:	Responsible Party Birthdate	Responsible Party SSN
Name of Employer and Address	Business Phone	Occupation
Primary Care Physician	Business Phone	Fax Number
PCP Address	City	State Zip
Reason for Visit	Referred By (include address and phone if not PCP)	
Emergency Contact	Relationship to Patient	Phone

Workers' Compensation? ☐ Motor Vehicle Accident? ☐ **If yes, put W/C or MVA carrier below**	Date of Accident	Treatment Authorized By
Claim #	WC or MVA Insurance Phone #	

Primary Insurance Company Address	Is insurance through your employer? ☐ Yes ☐ No

Subscriber Name	Subscriber Date of Birth	Policy #	Group #
Secondary Insurance Company Address		Policy #	Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to Washington Sleep Center for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release my insurance company or its agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any medical treatment or procedure.

_____ _____

Patient, Parent, or Guardian Signature (if child is under 18 years old) Date

WASHINGTON SLEEP CENTER

LIST OF CURRENT PATIENT MEDICATIONS

NAME _____

* Please list all of your current prescription medications and over-the-counter medications by name, dosage, and frequency AS PRESCRIBED OR RECOMMENDED
* Bring in your prescribed medications that you need to take at night or the following morning.

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please list any medications to which you are allergic:

_____

_____

Other allergies:

_____

_____

Please indicate any special diet requirements:

_____

_____

Have you ever taken medication to help sleep? If so, type and amount:

_____

_____

WASHINGTON SLEEP CENTER

PATIENT QUESTIONNAIRE

Today's Date: _____/_____/_____ Date of Sleep Testing: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Best time of day and number to reach you: _____

Current Weight: _____ Height: _____ Sex: Male / Female

"X" OR CIRCLE THE CORRECT ANSWER OR WRITE REQUESTED INFORMATION.

1.	A. Describe the sleep or wake problem that concerns you. B. Do any other members of your family have sleep problems? If yes, explain.			
2.	How long have you had this problem?			
3.	Do you snore?	Never	Occasionally	Often
4.	Have you been told you stop breathing in sleep?	Never	Occasionally	Often
5.	Do you have a headache when you awaken?	Never	Occasionally	Often
6.	Are you sleepy during the day?	Never	Occasionally	Often
7.	Are you sleepy when driving?	Never	Occasionally	Often
8.	Do you fall asleep unintentionally?	Never	Occasionally	Often
9.	How long does it take you to fall asleep at night?	_____ Minutes _____ Hours		
10.	A. Do you awaken during your night's sleep	Never	Occasionally	Often
	B. How long does it take you to get back to sleep?	_____ Minutes _____ Hours		
	C. Do you know why you awaken?			
11.	Are you restless during sleep?	Never	Occasionally	Often
12.	Do you, or have you been told that you frequently kick your legs during sleep?	Never	Occasionally	Often

13.	Do you experience restless legs (crawling or aching feelings, and inability to keep legs still)?	Never	Occasionally	Often
14.	Do you experience vivid, dream-like scenes even though you think that you are awake?	Never	Occasionally	Often
15.	Do you experience any kind of pain or physical discomfort?	Never	Occasionally	Often
16.	Do you have persistent, repeating, or violent dreams?	Never	Occasionally	Often
17.	Have you ever acted out your dreams or woke up doing so?	Never	Occasionally	Often
18.	Do you awaken from sleep screaming, violent, and confused?	Never	Occasionally	Often
19.	A. Have you ever had seizures or epilepsy?	Never	Occasionally	Often
	B. If so, when?			
20.	Have you been told that you grind your teeth in sleep?	Never	Occasionally	Often
21.	Do you have a sour or acid taste in your mouth during sleep?	Never	Occasionally	Often
22.	Do you have heartburn or chest pain during sleep?	Never	Occasionally	Often
23.	Do you gag, choke, or cough during sleep?	Never	Occasionally	Often
24.	Do you ever feel short of breath during sleep?	Never	Occasionally	Often
25.	Is your sleep disturbed during the night because of:			
	A. Having thoughts racing through your mind?	Never	Occasionally	Often
	B. Feeling sad or depressed?	Never	Occasionally	Often
	C. Anxiety (worry about things)?	Never	Occasionally	Often
	D. Do you have a fear of not being able to sleep once you have awakened during the night?	Never	Occasionally	Often
26.	How long, altogether, are you awake during your night's sleep time?	_____ Minutes _____ Hours		
27.	What is your total number of hours of sleep that you usually get at night? (Do not include time that you spend awake in bed during the night)	_____ Minutes _____ Hours		
28.	What time do you usually go to bed?	Weekdays: _____ AM/PM Weekends: _____ AM/PM		
29.	A. What time do you usually get up in the morning?	Weekdays: _____ AM/PM Weekends: _____ AM/PM		

	B. Describe how you feel when you get up in the mornings.			
30.	Do you have a problem with fatigue (tiredness, exhaustion, lethargy) even when you are NOT sleepy?	Never	Occasionally	Often
31.	Do you have weak knees or episodes of muscular weakness (paralysis or inability to move) when laughing, angry, or in other emotional situations?	Never	Occasionally	Often
32.	Do you feel you have a sexual concern?	☐ YES ☐ NO		
33.	How MUCH stress do you have at the present time?	Not much	Some	A lot
34.	A. Are you claustrophobic?	☐ YES ☐ NO		
	B. If yes, please explain:			

35. Please describe your medical history — Explain

Hypertension:	YES	NO	_____
Heart problems:	YES	NO	_____
Lung problems:	YES	NO	_____
Diabetes:	YES	NO	_____
Thyroid problem:	YES	NO	_____
Stroke or other neurological problems:	YES	NO	_____
Cancer:	YES	NO	_____
Sinus or nose problems:	YES	NO	_____
Heart burn:	YES	NO	_____
Depression:	YES	NO	_____
Hallucinations:	YES	NO	_____
Mood swings:	YES	NO	_____
Arthritis:	YES	NO	_____
Chronic pain:	YES	NO	_____
Allergies:	YES	NO	_____

36.	List Surgeries _____ _____			
37.	Do you have nasal stuffiness or congestion during sleep?	Never	Occasionally	Often
38.	A. Do you smoke or have you smoked?	☐ YES ☐ NO		
	B. If yes, how long have you or did you smoke?			
	C. How many packs per day?			
	D. When did you quit?			
39.	A. Do you drink alcohol?	☐ YES ☐ NO	Occasionally	Often
	B. How much per week?			
40.	A. Do you use recreational drugs?	☐ YES ☐ NO		
	B. Which ones?			
41.	A. Do you use caffeinated beverages?	☐ YES ☐ NO		
	B. What type?			
	C. How much per day?			
	D. Last cup or glass of the day at?			
42.	What is your occupation?			
43.	A. Are your working hours variable?	☐ YES ☐ NO		
	B. Explain:			
44.	A. Have you had a sleep evaluation or study before this? If yes:	☐ YES ☐ NO		
	B. When?			
	C. What kind?			
	D. Where?			
45.	Use this space for anything you would like to add.			

WASHINGTON SLEEP CENTER

EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

Age: _____ Sex: ☐ M ☐ F

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't 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:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading.....	
Watching TV.....	
Sitting, inactive in a public place (e.g. a theater or a meeting).....	
As a passenger in a car for an hour without a break.....	
Lying down to rest in the afternoon when circumstances permit.....	
Sitting and talking to someone.....	
Sitting quietly after a lunch without alcohol.....	
In a car, while stopped for a few minutes in traffic.....	
Total.....	

Score:	
0-10	Normal range
10-12	Borderline
12-24	Abnormal

WASHINGTON SLEEP CENTER

BED PARTNER QUESTIONNAIRE

THIS PAGE IS TO BE COMPLETED BY YOUR BED PARTNER, IF APPLICABLE. We often find that the information provided by the patient's bed partner can be vital in assisting the diagnosis of sleep disorder. Your cooperation is greatly appreciated.

How often does your bed partner:

1.	Snore?	Never	Occasionally	Often
2.	Snore loudly enough to disturb your sleep?	Never	Occasionally	Often
3.	Stop breathing during his/her sleep?	Never	Occasionally	Often
4.	Gasp for breath, cough, choke?	Never	Occasionally	Often
5.	Kick during sleep?	Never	Occasionally	Often
6.	Fall asleep before going to bed?	Never	Occasionally	Often
7.	Start to doze off while driving?	Never	Occasionally	Often
8.	Appear sleepy during the day?	Never	Occasionally	Often
9.	Toss and turn while sleeping?	Never	Occasionally	Often
10.	Act out his/her dreams?	Never	Occasionally	Often
11.	Talk in his/her sleep?	Never	Occasionally	Often
12.	Wake in his/her sleep?	Never	Occasionally	Often
13.	Get out of bed during the night?	Never	Occasionally	Often
14.	Have you noticed any personality changed? _____ _____ _____			
15.	Please use this space below to report any information you believe to be pertinent. _____ _____ _____			

WASHINGTON SLEEP CENTER

RECEIPT OF NOTICE PRIVACY PRACTICES WRITTEN ACKNOWLEDGE FORM

I, _____, have received a copy of the Washington Sleep Center's Notice of Privacy Practices.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OR THIS PRACTICE) MAY BE USED AND DISCLOSED WITH YOUR PERMISSION AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (IIHI).

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHA). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the documentation of treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following information.

- How we may use and disclose your IIHI
- Your privacy rights to your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision of amendment to this notice will be effective for all of your records that our practice has created or maintained in the past and for any of your records that we may crate or maintain in the future. Our practice will post a copy of our current notice in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THE NOTICE, PLEASE CONTACT:

The Washington Sleep Center

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION (IIHA) IN THE FOLLOWING WAYS:

1. Treatment
2. Payment
3. Health Care Operations
4. Appointment Reminders
5. Treatment Options
6. Health Related Benefits and Services
7. Release of Information to Family/Friends
8. Disclosure Required by Law

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following is a list of categories in which we may use or disclose your identifiable individual health information.

1. Public Health Risk
2. Health Oversight Activities
3. Lawsuits and Similar Proceedings
4. Law Enforcement
5. Deceased Patient
6. Organ and Tissue Donation
7. Research
8. Serious Threats to Health and Safety
9. Military
10. National Security
11. Inmates
12. Worker's Compensation

E. YOUR RIGHTS REGARDING YOUR IIHI

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to File a Complaint
7. Right to Provide an Authorization of Other Uses and Disclosures

WASHINGTON SLEEP CENTER

FREQUENTLY ASKED QUESTIONS REGARDING YOUR SLEEP STUDY

Do I need a prescription before my sleep study is performed?

Yes. It is your responsibility to obtain a physician's prescription prior to receiving services.

What happens after my sleep study is completed?

Our Board Certified Sleep Physician will evaluate the study data and produce an interpretive report and recommendations, which may include the need for a second sleep study. These reports will be provided to your referring physician for their records.

When will I learn of the results of my sleep study?

Your study analysis and reports will be completed and forwarded to your referring physician within 10 business days.

If the results of your sleep study indicates a significant occurrence of sleep apnea, the Sleep Physician will recommend a second study. In this study, you will be introduced to the normally recommended treatment for sleep apnea called CPAP (Continuous Positive Airway Pressure). The Sleep Technologist will explain CPAP and its benefits in more detail when you arrive for your study. The Sleep Physician may also recommend certain lifestyle changes to reduce the severity of your sleep apnea, as well as inform you of alternative treatment options (i.e. oral appliance) where appropriate.

Who will provide the CPAP machine?

After completion of your second sleep study CPAP titration, the Sleep Physician will forward the interpretation for the recommended pressure for your machine to your referring physician within 10 business days. Your referring physician will then write the prescription for your CPAP, also known as Durable Medical Equipment. Once we receive the prescription, we will forward it to a Home Healthcare Company. The Home Health Company will work with your insurance company to confirm coverage and arrange for the delivery of the CPAP machine to your home, or other location, where you will be trained on its proper use.

WASHINGTON SLEEP CENTER

INSURANCE AND FINANCIAL POLICY

Washington 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. In order to achieve this goal, we will 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 an authorization from the insurance carrier, it is important to understand that you are ultimately responsible for obtaining such referral or authorization prior to the commencement of your test. Our office will attempt to assist you in this process. Please notify our office if you have questions or need further assistance with this process.

5. In accordance with Federal Statutes and the State Balance Billing Law, we must balance bill 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, per your contract with your insurance carrier. 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.

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

If you have any questions about the above information or any uncertainty regarding your coverage, please contact your carrier. Our billing department will attempt to pre-verify your coverage; however it is only a quote of benefits and not a guarantee of payment.