REM Sleep Center - San Marcos

2005-B Medical Parkway
San Marcos, TX 78666
512-452-0004 opt.2

Appointment Information:

Date: _____

Time: _____

Amount Due: _____

****** If you need to cancel or reschedule your sleep study we require 2 business days' notice. ******

If you are not able to fully care for yourself and/or require a caregiver, REM Sleep Center must be contacted immediately. If a caregiver is required, they must stay for the entire sleep study. Thank you for your cooperation!

Please arrive no more than 15 minutes prior to your appointment. The hook up will take approximately one hour and your study will begin shortly afterwards. Your sleep study will end between 5:00 and 5:30 am. If you need to arrive earlier or be awakened before 5:00 a.m., let us know in advance so we can adjust the schedule.

Our Sleep Center staff will make your stay with us as pleasant as possible. If you have any questions or concerns, feel free to contact us between 9am to 5pm Monday Friday at 512-452-0004 (option 2). Thank you for choosing REM Sleep Center. We look forward to helping you soon!

About your sleep study

A sleep study is a diagnostic procedure which measures physiological parameters during sleep. This is a noninvasive procedure meaning that no needles will be involved and the procedure is painless. A sample of your sleep patterns is needed to help diagnose any sleep disorders. Body sensors are used to allow us to monitor and record the quality of your sleep. They are applied so that you may turn and move in your sleep as you normally would. Surprisingly, most people will sleep the way they usually do at home. A technician will be available for assistance all night and bathroom visits are easily accommodated. Our staff will try to make your sleeping environment as comfortable as possible. Please remember, this is not a performance test, only a sample of how you sleep.

The following parameters will be monitored during your study:

- EEG/Brain Waves (Electrodes placed on the scalp)
- EKG/Heart Rate (Electrodes placed on the chest)
- EOG/Eye Movements (Electrodes placed above and below eyes)
- EMG/Muscle Tension (Electrodes placed on the chin)
- EMG/Muscle Tension (Electrodes placed on both legs)
- Airflow/Breathing (Sensors attached near nose and mouth)
- Respiratory Effort (Elastic belts placed around chest and stomach)
- Oximetry/Blood Oxygen Levels (Small sensor attached to finger)

******Please review the following page to ensure you are properly prepared ******

If you did not do so at scheduling, please let us know prior to your sleep study if you:

Currently use CPAP/BiPAP and/or supplemental oxygen at home

Need assistance getting in and out of bed

Cannot walk up and down stairs on your own

Have hair extensions and/or weaves. These can obstruct access to your scalp

Have any neurological deficits.

Have any sensitivities to adhesives such as tape.

What we need from you is the following:

Complete and sign the enclosed paperwork prior to your arrival.

Please bring a list of any medications you currently use.

Please bring all insurance cards and a photo ID.

Bathe and make sure that your hair is clean and free from all oils, gels or sprays and make-up. It is important that the technologist have access to your scalp.

Bring something comfortable to sleep in (pajamas, tee-shirt and shorts along with a robe for comfort.)

DO NOT wear silk, satin, or nylon – they can cause static and may interfere with the study.

If you use CPAP/BiPAP at home, please bring your mask and headgear.

Helpful hints for the day of the study:

Make sure to bring any medications you will need for the night. If you have difficulty initiating and/or maintaining sleep, you may want to discuss this with your referring physician to ask about a sleep aid. Do not take any sleep aids prior to arrival for your study and let your technologist know when and what you are taking.

Avoid caffeine and alcohol after 4pm.

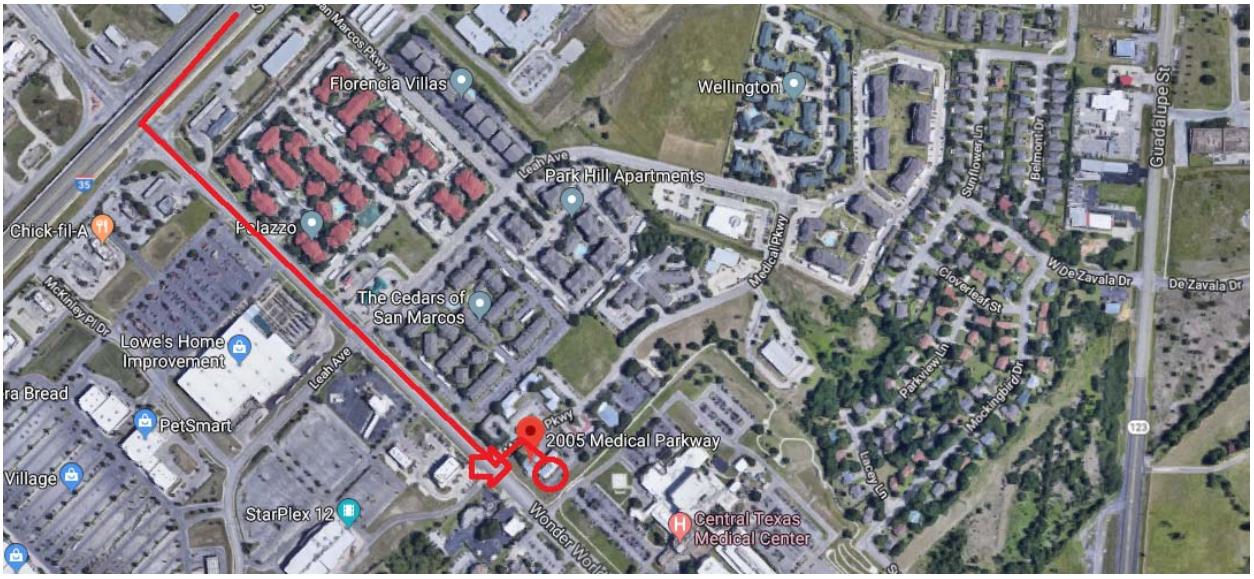
Please be clean shaven unless you normally wear a beard.

If you have something from home that would make your stay more comfortable (such as a favorite pillow) please feel free to bring it with you.

If you have a cold or feel ill, please contact the lab immediately as we may need to reschedule.

Please do not bring any unecessary valuables such as credit cards/cash not to be used as payment or jewelry.

REM Sleep Center
2005-B Medical Parkway
San Marcos, TX 78666
512/452-0004 opt. 2



Directions:

From I-35

Exit 202 Wonder World Drive

Turn East onto Wonder World Drive (from I-35 South turn Left, from I-35 North turn right)

Turn Left onto Medical Parkway (If you pass Central Texas Medical Center, you have gone too far)

Turn right into the first parking lot on the right hand side

2005-B is straight ahead.

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required to protect the privacy of your medical information and to provide you with a Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THE INFORMATION.

We use the health information about you for treatment, to obtain payment for the treatment, for administrative purposes, and to evaluate the quality of care that you receive.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of your disclosures of your medical information, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask a REM Sleep Center employee and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact us at (512) 452-0004, or stop by our office between the hours of 9am – 5pm Monday through Friday or call the numbers listed below after hours.

- 2005-B Medical Parkway San Marcos, TX 78666 512-452-0004

Customer Rights & Responsibilities

Rights: Every customer of REM Sleep Center should expect and receive quality care related to his/her Sleep Study needs. As a customer, you have the right to:

1. Be treated with dignity, courtesy and respect.
2. Receive reasonable coordination and continuity of sleep study services from referring agency.
3. Receive a timely response from Home Respiratory when home medical equipment is needed or has been requested.
4. Be fully informed of REM Sleep Center's policies, procedures, and charge for services, including eligibility for third party reimbursement to the extent it is available at the time of delivery--and receive an explanation of all forms that are requested to be signed.
5. Receive sleep study services regardless of race, religion, political belief, sex, social status, age or handicap.
6. Receive proper identification of name and title from personnel providing services.
7. Participate in decisions concerning home medical equipment needs.
8. Have all records and all communications, written or oral, between customers and health care providers treated confidentially as outlined in HIPAA.
9. Access all health records pertaining to the customer and the right to challenge and have the records corrected for accuracy.
10. Express dissatisfaction and suggest changes in any service without coercion, discrimination, reprisal, or unreasonable interruption in service.
11. Receive written information on the company's policy for receiving and resolving complaints or concerns.
12. Be assured that all rights shall be honored by the company's staff.
13. Be informed of all responsibilities regarding home medical equipment usage and services.
14. Refuse all care/services for whatever reason at any time to the extent permitted by law.

Customer Rights & Responsibilities *(continued)*

Responsibilities:

In addition, every customer should be aware of certain responsibilities that will help assure a pleasant relationship with REM Sleep Center. As a customer, you have the responsibility to:

1. Be fully informed of the company's policies, procedures, and charge for services, including eligibility for third party reimbursement to the extent it is available at the time of delivery--and receive and explanation of all forms that are requested to be signed.

2. Patient agrees to notify the company of any change in patient insurance, address, physician, etc.

3. Patient agrees to accept all financial responsibility for sleep study services furnished by the company.

CUSTOMER COMPLAINTS

Any customer who feels his or her rights have been denied, who desires further clarification of rights, or who desires to lodge a complaint or express contentment with any aspect of service, including concerns about patient safety and the risk of falls, should contact us through our main telephone number, without fear of reprisal by the company or by any of its employees. If the issue cannot be resolved via a telephone call with a customer service representative, the matter will automatically be forwarded to the appropriate corporate manager. If you have a complaint or suggestion of any kind about REM Sleep Center, please call our office at (512) 452 - 0004.

Patient Name: _____

CUSTOMER ACCOUNT AGREEMENT

*****Please take the time to carefully read before signing*****

1) Unless prior arrangements have been made with the Bookkeeping Dept., full payment of the bill is due at time of service.
2) Unless prior arrangements have been made with the Bookkeeping Dept., the patient is responsible for any and all portions of the bill not paid by insurance.
3) If you believe there is an error in your bill you will contact the Bookkeeping Dept., within 10 days of receipt of your statement.

X _____

Patient/Caregiver Date Technician's Initials

INFORMED CONSENT TO PHOTOGRAPH AND/OR VIDEO TAPE

*****Please take the time to carefully read before signing*****

Photographs may be taken for documentation of any facial, nasal, jaw or neck abnormalities. Videotaping or obtaining digital video and audio is done in all Sleep Testing to document cases of unusual behavior or breathing patterns connected with sleep disorders. I understand that these photographs and/or videotapes will be a part of my medical record and are not for publication. I hereby grant permission REM Sleep Center to take photographs and/or use digital video and audio recording.

X _____

Patient/Caregiver Date Technician's Initials

INFORMED CONSENT FOR CPAP/BIPAP TITRATION

*****Please take the time to carefully read before signing*****

I hereby acknowledge that I have been informed of and understand the purpose of the treatment of Continuous or BiLevel Positive Airway Pressure (CPAP/BiPAP) and the associated risks (listed below) and alternatives, and that I have had the opportunity to have my questions concerning treatment answered by a qualified technician.

Risk Factors Associated with PAP Therapy:

Aspiration, Nasal Congestion, Minor Eye Irritation, Shortness of Breath, and Skin Irritation

X _____

Patient/Caregiver Date Technician's Initials

Patient Name: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Referring doctor (MD, DO, DDS, Etc.): _____

Date of Birth: _____ Age: _____ Height: _____Weight: _____

Address: _____ Home Phone: _____

_____ Email Address: _____

SYMPTOMS CHECKLIST

1.	Do you snore?	**Yes** ___**No** ___ **Sometimes**____
2.	Do you stop breathing in your sleep?	**Yes** ___**No** ___ **Sometimes**____
3.	Do you awaken suddenly with a choking sensation?	**Yes** ___**No** ___ **Sometimes**____
4.	Do you awaken with headaches in the morning?	**Yes** ___**No** ___ **Sometimes**____
5.	Do you have trouble breathing though your nose?	**Yes** ___**No** ___ **Sometimes**____
6.	Do you awaken with a dry mouth?	**Yes** ___**No** ___ **Sometimes**____
7.	Do you awaken at night to urinate?	**Yes** ___**No** ___ **Sometimes**____
8.	Do you have restless legs?	**Yes** ___**No** ___ **Sometimes**____
9.	Do you feel sleepy during the day?	**Yes** ___**No** ___ **Sometimes**____
10.	Do you feel fatigued during the day?	**Yes** ___**No** ___ **Sometimes**____
11.	Do you have problems with memory or concentration?	**Yes** ___**No** ___ **Sometimes**____

List all prescription and other medications: [PLEASE PRINT VERY CLEARLY] - use back if necessary

Patient Name: _____ Date: _____

MEDICAL HISTORY (Check all that apply)

Do you now have or ever had:	Yes	No		***Do you now have or ever had:***	Yes	No
High Blood Pressure (HTN)				Nasal Fracture		
Chronic Obstructive Pulmonary Disease				Nasal Surgery		
Nocturnal Esophageal Reflux (GERD)				Sinus Problems		
Mood Disorders				Allergies		
Heart Problems				Asthma		
Ischemic Heart Disease				Insomnia		
History of Stroke				Tonsillectomy		
Diabetes				Swelling of Hands or Feet		

SLEEP RELATED HEALTH-CARE:

1. Have you ever had a sleep study? _____
   a. If so, when was it done? _____
   b. Who ordered it? _____
   c. Where was it done? _____

2. Are you on CPAP/BiPAP therapy? _____
   a. If so, when did you start? _____
   b. What is your pressure setting? _____
   c. Who supplied your machine? _____

3. Are you on home oxygen? _____
   a. If so, when did you start? _____
   b. What company supplies your oxygen? _____

List all major surgeries: [PLEASE PRINT VERY CLEARLY] – use back if necessary

Please describe the sleep-related issue that brings you to the sleep center:

Patient Name: _____ Date: _____

EPWORTH SLEEPINESS SCALE

Please rate the chance of you dozing in the following situations:

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. theater or *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	_____
Add the numbers for a total:	_____

SOCIAL HISTORY

Have you ever smoked?	**Yes** _____**No**_____
If yes, for how many years?	_____
Average number of packs per day?	_____
Have you quit smoking?	**Yes** _____**No**_____
How long ago?	_____
Do you drink caffeinated beverages?	**Yes** _____**No**_____
If yes, how much per day?	_____
Do you drink alcoholic beverages?	**Yes** _____**No**_____
If yes, how many drinks/wk?	_____
Do you get regular exercise?	**Yes** _____**No**_____
If yes, how often?	_____

SLEEP HABITS

Normal Bedtime:	Weeknights: _____	Weekends_____
Normal Wake up time:	Weekdays:_____	Weekends_____

What position do you prefer to sleep in? __ Back __ Stomach __ Side

In a typical night, how many times do you wake to use the restroom? _____

Do you sleep with a fan or noise-maker? __ Yes __ No

Additional Notes: