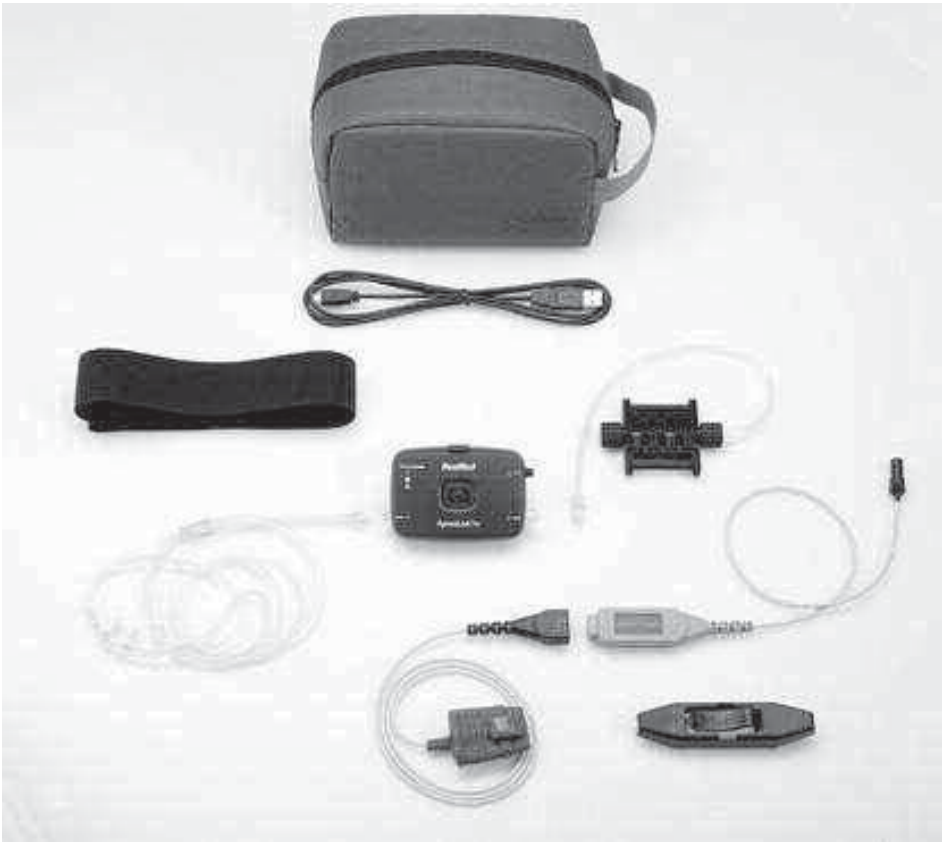
REM Sleep Center

2005-B Medical Parkway
San Marcos, TX 78666
512-452-0004 opt.2
(Mon-Fri/9am-3pm)

Home Sleep Studies are a simplified version of an in-lab study. The device is worn to bed and uses a small array of sensors to collect data on sleep quality. It will be worn for one or two nights, depending on your doctor's orders, and then returned the following day. The data will then be sent to your doctor to be analyzed to determine whether or not you need treatment for Sleep Apnea.

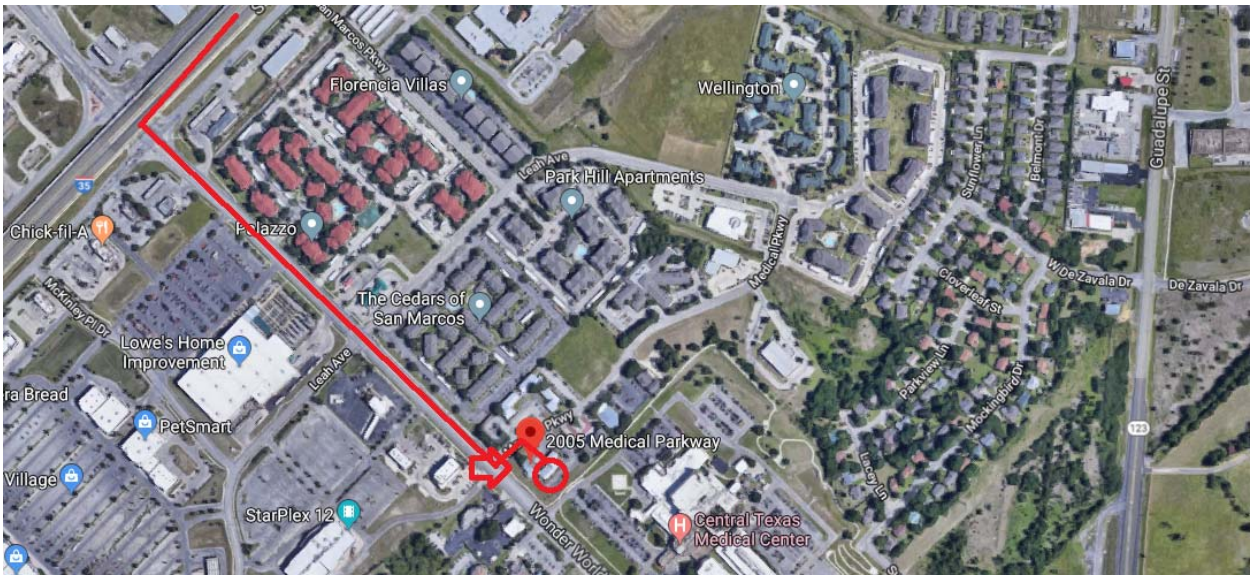
The device you will be using is the **ResMed Apnea Link Air**. It is simple to use and comfortable to wear.



Directions to our office can be found on the next page. Please fill out the Loaner agreement and 3-page Medical History Questionnaire prior to your appointment and bring with you. Please complete the Home Sleep Test Nightly Diary each morning after you use the device and return with the device.

If you have any questions or concerns please call REM Sleep Center at 512-452-0004 option 2

REM Sleep Center
Total Respiratory, Inc
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.

REM Sleep Center

2005-B Medical Parkway, San Marcos, TX 78666
O: 512-452-0004 / F:512-452-4144

Loaner Equipment Agreement
Terms and Conditions

Client ID#_____

****Please read carefully****

I,_____, understand the equipment listed below was received by me in good working condition and will take full responsibility for this equipment. The retail purchase price has been disclosed next to each piece of equipment and I agree to pay full retail purchase price should equipment not be returned or has damage of any kind. This includes cigarette smoke.

All loaned equipment must be returned by the following date, _____. I understand and agree to pay **$45.00** per each item not returned per day. In addition, I also understand and agree to pay the retail purchase price of all equipment not returned after 5 days of the return date. This is your only notification of these charges. Accurate Respiratory, Inc. will not notify you prior to charging your credit card. All charges are final and will not be prorated for any reason.

Items Provided	Item Description	Retail Price	Items Returned	Damaged	Not Returned
[ ]	Oximeter	$850.00	[ ]	[ ]	[ ]
[ ]	ApneaLink Air	$1995.00	[ ]	[ ]	[ ]
[ ]	XPOD	$500.00	[ ]	[ ]	[ ]
[ ]	Effort Sensor	$500.00	[ ]	[ ]	[ ]
[ ]	Clip-on Holder	$5.00	[ ]	[ ]	[ ]
[ ]	Elastic Belt	$50.00	[ ]	[ ]	[ ]
[ ]	Finger Probe (L)	$200.00	[ ]	[ ]	[ ]
[ ]	Finger Probe (S)	$200.00	[ ]	[ ]	[ ]
[ ]	Rechargeable Batteries	$10.00	[ ]	[ ]	[ ]
[ ]	Nasal Cannula	$0.00	--	--	[ ]
[ ]	Travel Bag	$45.00	[ ]	[ ]	[ ]
[x]	Daily Rental	$45.00/day if not returned by the return date			

Credit card info: *(Photo Copy of Credit Card Required)*

Name on Card:_____

Card Number:_____ Exp date:_____ Code:_____

Billing address of card: [ ] On File

_____

I,_____, agree to all terms and conditions of this agreement. I agree and authorize charges for items marked under the Items Provided column which I have not returned or damaged to the above credit card. I will pay **$45.00** per each item not returned per day. The rental charges will begin on_____. I agree to pay all retail purchase prices listed under the Retail Price column if not returned within 5 days of the return date on or after _____.

Client Signature:_____ Date:_____

Employee Witness:_____

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: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

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

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

Address: _____ Social Security # _____

_____ 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

Name of Medication:	Reason for Medication:

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

Type of Surgery:	**Year of Surgery:**

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 much and how often? _____

Do you get regular exercise? _____**Yes** _____**No**
If yes, how often? _____

SLEEP SCHEDULE

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

Additional Notes:

APNEA LINK AIR HOME SLEEP TEST INSTRUCTIONS

****Instructional video available on our website at www.remsleepstudy.com.
Please go to Patients, then Home Sleep Testing****

THERE ARE THREE SIMPLE COMPONENTS USED WITH YOUR HOME SLEEP TEST:

1) Black Belt with Velcro attachment
2) Gray Finger Probe
3) Clear Nasal Cannula

The unit has two AAA batteries that have been fully charged. **If you are using the device for 2 nights you will need to replace the batteries prior to second night testing. We have included the replacement batteries**. **To use the Home Sleep Test (HST)**:

Stand up and wrap the black belt around the body directly below the chest and use the Velcro to attach the two sides of the belt.

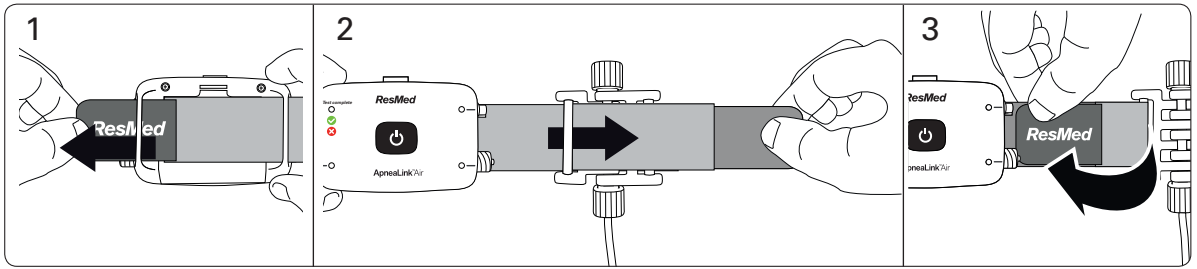
You may now sit down and put the gray finger probe on the index finger of either hand. Leave a little slack to the connector wire and, using tape or bandaid, secure the wire to the wrist, keeping the probe on and allowing range of motion to the hand.

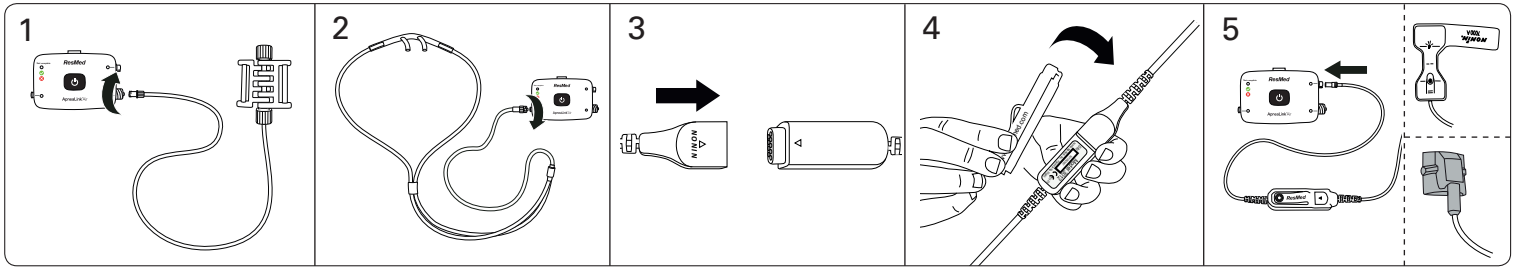
Remove the clear nasal cannula from the plastic bag. The cannula can either be angled inward or outward. Be sure that it is angled inward for best comfort. Attach the cannula to the HST unit in the front on the left side by twisting it to the right (clockwise) until it is fully attached. Gently place the cannula into the nose (angled inward). Lift head and raise the bolo tie up to just below the chin.

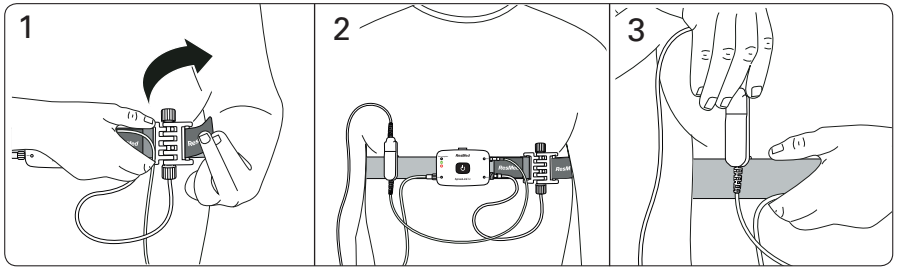
When ready for bed, with the HST all set up, press the start/stop button in the middle in front of the HST until the green light comes on. In the morning, press and hold down the same button until the green light goes off. Lower the bolo tie and remove the cannula. Remove probe from finger. Stand up and detach the Velcro and remove the belt.

IF ANY OF THE 3 SMALL LIGHTS GLOW RED, CHECK THE THREE CONNECTIONS, AS ONE HAS BECOME DETACHED. RE-CONNECT AND THE DEVICE SHOULD WORK FINE.

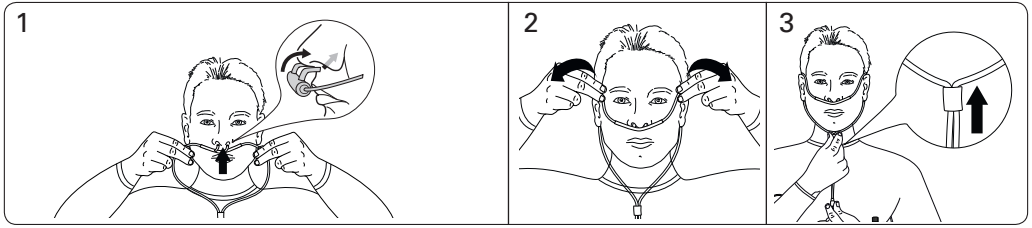
ResMed

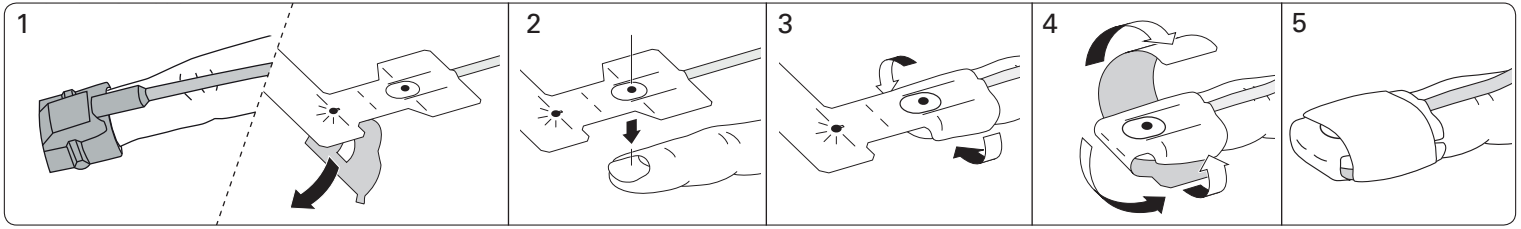


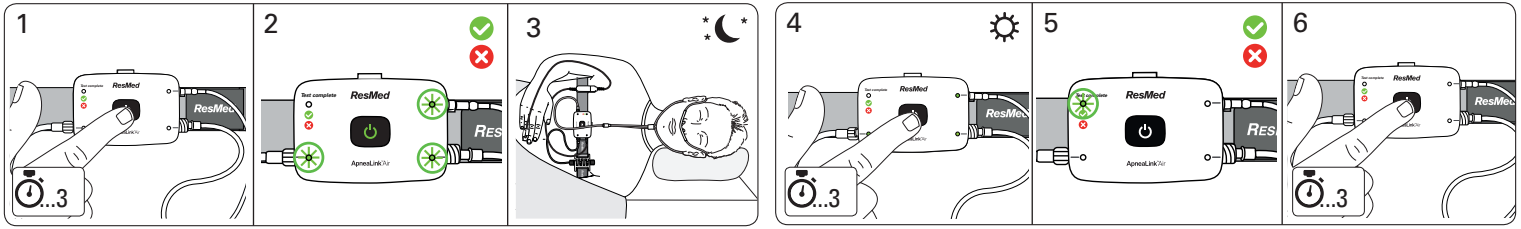




ApneaLink™ Air







Manufacturer: ResMed Germany Inc. Fraunhoferstr. 16 82152 Martinsried Germany. **Distributed by:** ResMed Ltd 1 Elizabeth Macarthur Drive Bella Vista NSW 2153 Australia. ResMed Corp 9001 Spectrum Center Boulevard San Diego CA 92123 USA. See www.resmed.com for other ResMed locations worldwide.
For patent information, see www.resmed.com/ip. ApneaLink is a trademark of ResMed R&D Germany GmbH and registered in U.S. Patent and Trademark Office. CE 0123

Global leaders in sleep and respiratory medicine
www.resmed.com

ResMed

REM Sleep Center – Home Sleep Test Nightly Diary

2005-B Medical Parkway • San Marcos, Texas 78666
Phone: (512) 452-0004 opt 2 • Fax: (512) 452-4144

Patient Name: _____ DOB: _____

NIGHT 1: With Oral Aplliance: YES NO (If yes, How many half turns?)_____

Date: _____ Bedtime:_____ Awake time:_____

Was the power light still on when you woke up? YES NO
Did a red light occur during the night? YES NO (If yes, how did you adjust?)
_____
Describe any unusual events during the night:
_____
_____

Rate on friendliness, efficiency and knowledgeability of the scheduling staff: (Please Circle)
Great Very Good Okay Poor Very Poor

Rate the explanation of the use of the device: (Please Circle)
Great Very Good Okay Poor Not helpful at all

Rate the ease of putting on and operating the device: (Please Circle)
Very Easy Moderately Easy Moderately Difficult Very Difficult

Suggestions:_____
_____
_____
_____

(Please make sure you have replaced the batteries for Night 2 if applicable)

NIGHT 2: (IF APPLICABLE) With Oral Aplliance: YES NO (If yes, How many half turns?)_____

Date:_____ Bedtime:_____ Awake time:_____

Was the power light still on when you woke up? YES NO
Did a red light occur during the night? YES NO If yes, how did you adjust?
_____
Describe any unusual events during the night:
_____
_____

Include this form in the bag with the device when returning to REM Sleep Center
Date Returned:_____