Sound Sleep

Sleep Soundly · Nurture Life

OFFICE USE:

Height:_____
Weight:_____
BP_____
HR:_____
Neck C:____

Adult Sleep History, New Patient

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

Home Address: _____

City:_____State:_____Zip code:_____

Email Address:_____

Home phone: ( )_____ Mobile phone:( )_____

Marital Status: ☐ Married ☐ Single

Birth Date:_____Age:_____Sex:_____Height:_____Weight:_____

*Occupation:*_____*Employer:*_____

Referring Physician: _____

Address:_____

City:_____State:_____Zip code:_____

Phone number:_____Fax:_____

Primary Physician (if different from referring):_____

Address:_____

City:_____State:_____Zip code:_____

Phone number:_____Fax:_____

Preferred Pharmacy: _____ Phone#_____

Pharmacy Address: _____City_____State_____Zip_____

Prior Sleep Study (if applicable):

When: _____ Where:_____

Do you have copies of the reports: _____ Do you have a CPAP or BPAP? _____

*Sound Sleep LLC, 400 Holiday Court, Suite 103, Warrenton VA 20186 - 571 James Madison Hwy, Suite B, Culpeper VA 22701 * Ph 540-699-0608 * Fax 540-680-2427*
*soundsleep103@gmail.com * www.soundsleep.us*

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Print Name:_____

1.	What is your bedtime:	PM	AM
2.	What is your *final* wake up time:	PM	AM
3.	Do you have trouble getting to sleep at night?	YES	NO
4.	On the average, how long does it take you to fall asleep?	Minutes	Hours
5.	How long are you using electronic devices IN BED before sleep?	Minutes	Hours
6.	Do you take any medications/supplements to help you sleep? Please list here:		
7.	Have you ever used Alcohol to help you fall asleep easier?	YES	NO

8.	Once asleep, how often do you wake up at night?		
9.	How much time do you spend awake at night?	Minutes	Hours
10.	Do you wake up too early, not being able to sleep again?	YES	NO
11.	Do you use any electronic devices during nighttime awakenings?	YES	NO
12.	Do you Snore at night?	YES	NO
13.	Do you wake up from sleep gasping or short of breath?	YES	NO
14.	Has anyone said that your breathing pauses at night?	YES	NO
15.	How many total hours of actual SLEEP do you feel you get?	Hours	Minutes

16.	Do you feel rested in the morning?	YES	NO
17.	How much caffeine do you drink in the morning? Please circle type: (coffee/tea/soda/energy drinks)	Cups	Cans
18.	Are you tired during the daytime?	YES	NO
19.	Do you doze off if you are not active?	YES	NO
20.	Have you ever had sleepiness when driving?	YES	NO
21.	Do you take naps?	YES	NO
22.	If yes, how many times a week and for how long?	/week	/mins

23.	Do you have Nightmares?	YES	NO
24.	Have you ever acted out a dream, moving arms and legs?	YES	NO
25.	Have you injured yourself or a partner with nighttime movements?	YES	NO
26.	Do you talk in your sleep?	YES	NO
27.	Do you walk in your sleep?	YES	NO
28.	Any history of eating while asleep?	YES	NO

29.	Do you have the urge to move your legs at night?	YES	NO
30.	Does rest make the urge worse?	YES	NO
31.	Does getting up and moving help?	YES	NO
32.	Do these symptoms occur in the evenings?	YES	NO

33.	Have you had weakness in legs/muscles with strong emotion?	YES	NO
34.	Have you experienced sleep paralysis (can't move arms or legs upon awakening for a few seconds)	YES	NO
35.	Do you grind your teeth?	YES	NO
36.	Have you had recent changes in your mood/irritability/patience?	YES	NO

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Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations? How often do you feel tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to evaluate how they would affect 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 (please put appropriate number from above)
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: _____

Medical History:

Do you take any medications (pills, shots, vitamins, herbs, etc.)?

If yes, list below the names and amounts of all medications you are taking and state how often and why you take each one.

Medication	Dose	How often	Reason/Condition

Weight 3-5 years ago: _____

Allergies:

Medication:_____

Other: _____

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Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life? Not at all

Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem? Not at all

Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ **Your total score**

Total score categories:

0–7 = No clinically significant insomnia; 8–14 = Subthreshold insomnia;15–21 = Clinical insomnia (moderate severity) 22–28 = Clinical insomnia (severe).

Used via courtesy of www.myhealth.va.gov with permission from Charles M. Morin, Ph.D., Université Laval

Is there anything else that we missed that you would like to tell us about or discuss with the Doctor?

_____

_____

_____

_____

_____

Thank you for completing this Questionnaire.

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Print Name_____

INSURANCE INFORMATION

Primary Insurance Co.: _____ *Policy #:* _____ *Group #:* _____

Insurance Policy Holder Name: _____ Policy Holder Date of Birth: _____

Secondary Insurance Co.: _____ *Policy #:* _____ *Group #:* _____

Insurance Policy Holder Name: _____ Policy Holder Date of Birth: _____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Sound Sleep, LLC or any of its affiliates or agents, lenders, or any third-party servicer acting for Sound Sleep, LLC or any of its affiliates.

Patient Signature: _____ ***Date***: _____

EMERGENCY CONTACT

Last Name: _____ *First Name:* _____ *Middle Initial:* _____

Relationship to Patient: _____ *Sex: M / F*

Date of Birth: __/__/____ *Home Address:* _____

Cell Phone #: _____-_____-_____

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

GUARANTOR CONTACT *(please check at least one)* ☐ *Guarantor* ☐ *Policy Holder/Insured*

Last Name: _____ *First Name:* _____ *Middle Initial:* _____

Social Security #: _____-_____-_____ *Relationship to Patient:* _____ *Sex: M / F*

Date of Birth: ____/____/____ *Home Address:* _____

Home Phone # _____ *Cell Phone#* _____ *Work Phone#* _____

MEDICAL RECORDS RELEASE

Please complete the following information:

I approve the release my protected health information to the following physician/facility/entity and/or those directly associated in my medical care:

SOUND SLEEP, LLC

Printed Name of Patient/Representative _____

Patient Signature: _____ ***Date***: _____

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Print Name_____

Please review the following clinic policies and sign prior to your visit

- **Financial Policy:**

This consent applies Sound Sleep, LLC, or any of its affiliates or agents, lenders, or any third-party servicer acting for Sound Sleep or any of its affiliates.
I hereby authorize my insurance benefits to be paid directly to the physician and/or physician group for which I am financially responsible for all charges. I also consent to the release and re-disclosure of my medical record to enable or facilitate the payment, collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan.

If at any point you change insurance, or your insurance policy terminates or cancels coverage, you will be fully responsible for any and all charges that are not subject to being refiled with any new insurance provided. Most insurance(s) have timely filing requirements that if they are not met, we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy. If we are unable to refile your claims, you will be fully responsible for all charges. This includes any SECONDARY insurance related information as well.

- **Referral Policy:**

I understand that if my insurance carrier requires a written "Insurance Referral" from my Primary Care Physician, I am responsible for obtaining the insurance referral prior to being seen in our office and prior to be testing.
We recommend that all patients call and confirm this directly with your health insurance or check with your PCP office ahead of time. If an "insurance referral" has not been obtained before my appointment, I will be asked to sign a "Waiver Form" acknowledging that if the referral is not able to be obtained timely, I will be financially responsible for the charges incurred.

- **Cancellation Policy:**

Office Visit *appointments not cancelled with a minimum of 24-hour notice will be charged a* ***$50.00 cancellation fee****. This fee is NOT billable to your insurance carrier.*
In-Lab Sleep Study related appointments *not cancelled with a minimum of 3 business days will be charged a* ***$250.00 cancellation fee****. This fee is* ***NOT*** *billable to your insurance carrier.*
Home Sleep Study Related Appointments *not cancelled with a minimum of 24-hour notice will be charged a* ***$100.00 cancellation fee****. This fee is* ***NOT*** *billable to your insurance carrier.*

If you must cancel or reschedule your appointment, we ask that you contact us directly at 540-699-0608, (Monday-Friday 8:00am-4:00pm).

- **Consent for video and audio taping during sleep study (if applicable):**

As part of a diagnostic sleep study, video may be required. All information and data will be kept confidential.
I,_____, hereby authorize the use of video surveillance for the purpose of medical diagnosis.
If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

- **Sharing your protected Health Information:**

The HIPAA Privacy Act requires that we must obtain permission from you before we can share any health-related information which includes: Appointment dates, Insurance/Account billing, and treatment related information. If you would like for us to be able to share certain pieces of this information, please make sure you list their names below.

1. First Name: _____ Last Name:_____
   Date of Birth: _____Relationship:_____

2. First Name: _____Last Name:_____
   Date of Birth: _____Relationship:_____

☐ **I do not wish to share my medical information with anyone.**

Patient/Guardian Name: _____

Signature: _____
Date:_____ Relationship to Patient:_____

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Print Name:_____

CONSENT TO PARTICIPATE IN TELEMEDICINE

Patient Name:_____ ***Date of Birth***: _____

Physician Name: Dr. Mathur *Facility Name:* Sound Sleep LLC

I understand that telemedicine is the use of electronic information and communication technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand my health care provider will determine whether the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. I understand I can choose to stop telemedicine consult at any time.

I understand that:

- My health care professional and I will communicate by interactive video conferencing using a telehealth platform.
- My health care professional will have access to all the clinical tools available at a regular office visit. (e.g. prescription refills, appointment scheduling, patient education etc.)
- The Telehealth visit will require my vital signs. I understand I will provide my height in feet and inches, weight in pounds, blood pressure, temperature, and pulse rate.
- There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- It is my responsibility to be aware of my surroundings as my personal health will be discussed which has the potential to be overheard by those around me.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.
- The laws that protect privacy and the confidentiality of medical information also applies to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature ***Date***

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Print Name:_____

Article 1: *Agreement to Arbitrate*: It is understood that any dispute as to professional malpractice, that is as to whether any professional services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, a violation of informed consent, wrongful death, or of emotional distress or punitive damages will be determined by submission to arbitration as provided by Virginia law, and not by a lawsuit or resort to court process except as Virginia law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: *All Claims Must Be Arbitrated*: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by Dr. Mathur and by any practitioner or staff person, their partners, associates, associations, employees, agents and/or providers (hereinafter collectively referred to as "Practitioner") to a patient/client, including any spouse or heirs and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" or “client” herein shall mean both the mother and the mother's expected child or children. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (a) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Virginia statute of limitations, or (b) the Patient or claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. Filing by Practitioner of any action in any court by the Practitioner to collect any fee from the patient/client shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Practitioner, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: *Procedures and Applicable Law:* A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Practitioner, the amount of damages sought, and the names, addresses and telephone numbers of the patient/client, and (if applicable) his/her attorney. Within fifteen days after a party to this Agreement has given written notice to the other of demand for arbitration, the parties shall either determine a mutually acceptable arbitrator, or each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the arbitrator. Expenses of the arbitration shall be shared equally by the parties to this Agreement. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient/client shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to the Virginia Uniform Arbitration Act (Va. Code Ann. § 8.01-581.01 et. seq.) and applicable arbitration requirements therein and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: *Retroactive Effect*: The patient/client intends this agreement to cover all services rendered by Practitioner not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: *Revocation*: This agreement may be revoked by written notice delivered to Practitioner within 30 days of signature and if not revoked will govern all professional services received by the patient/client.

Article 6: *Severability Provision*: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Virginia law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I enter into this Agreement and I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF PROFESSIONAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND <u>YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL</u>. SEE ARTICLE 1 OF THIS CONTRACT.

Print Name: _____Signature: _____Date: _____

Dr. Mathur or her representative: _____

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