SPACE COAST
SLEEP DISORDERS CENTER

OVERNIGHT SLEEP STUDY INSTRUCTIONS

Dear Patient,

Thank you for choosing Space Coast Sleep Disorders Center. In order to provide you with the best possible service, please follow the instructions listed below:

1. Please complete all enclosed paperwork in this packet and email or fax back to us along with a copy of your driver's license and insurance cards to 321-255-9902. ***(If you are unable to fax, please consider downloading the Adobe Scan App on your mobile phone to convert paper documents to PDF format for an easy upload to email.)***

2. If you cannot keep your scheduled appointment, PLEASE contact us as soon as possible so we may re-schedule your appointment and attempt to accommodate another patient in your absence.

3. ***If you have a co-payment or deductible due and are paying with cash,*** **PLEASE BRING THE EXACT AMOUNT.** ***Our technicians do not carry change.***

PREPARING FOR YOUR SLEEP STUDY

1. Space Coast Sleep Disorders Center does not carry nor dispense any medications. Therefore, we request that you take your prescribed medications as usual, unless your physician instructs you otherwise. If you take any medications before bedtime or during the night, please bring them with you to take at the sleep lab.

2. Shower or bathe prior to coming in for your study. Please do not apply any lotions or creams to your face or hair. *Gentlemen*: Please no five o'clock shadows.

3. Make sure you have eaten your evening meal before coming in.

4. Please wear **loose** fitting comfortable clothes to sleep in. If you do not have pajamas, a pair of shorts and a tee shirt is appropriate. Please do **NOT** wear sweat pants.

5. Please leave all valuables at home. Do not bring personal pillows or blankets, we have extra pillows and blankets in stock.

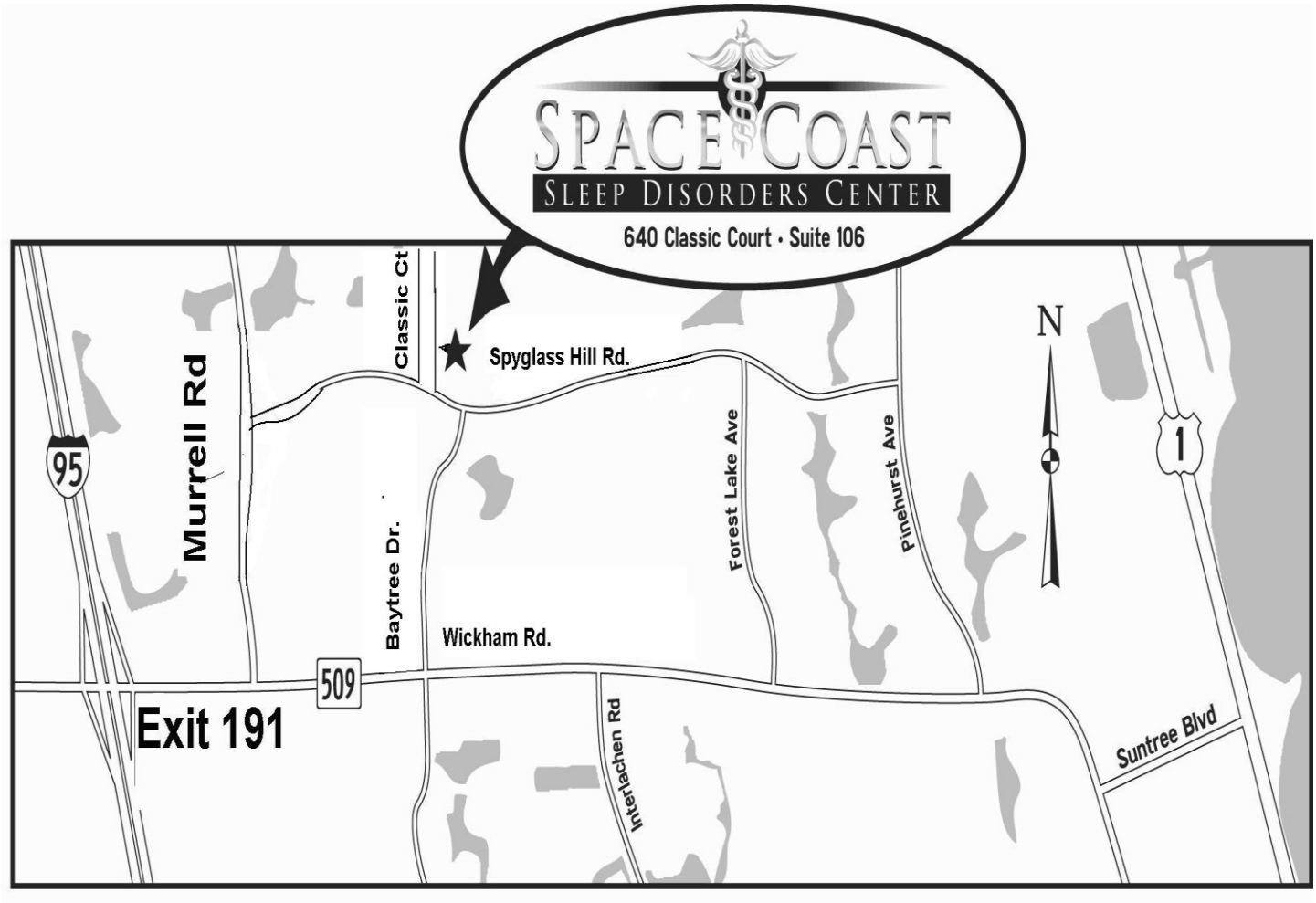
6. Please notify the Sleep Lab if you need to arrive and leave at a different time that was scheduled specified. **Please do not arrive earlier then your appointed time.**

Please be advised there will be a $200 cancellation fee charged to you if you do not give at least a 24 hour notice of cancellation. If you are scheduled for a weekend appointment, a 48 hour notice of cancellation is required.

Instructions for the Night of the Sleep Study

1. Bring any medications you may need at bedtime or during the night, this includes items such as Tums or Tylenol or other over the counter products.
2. Please do not consume any caffeine or alcohol products after 4:00 PM. This includes soda, tea, coffee, and chocolate.
3. Please bring toiletry items such as toothbrush, toothpaste, deodorant, razor, hair dryer, hairspray, brush/comb. Pajamas are recommended, but you may bring comfortable shorts and a tee shirt instead.
4. Please refrain from using cologne, aftershave or any other product with a strong scent.
5. Please refrain from using hairspray, gels, oils etc. in your hair on the night of your sleep study. We use paste to secure electrodes to your scalp and any amounts of the above items will make it harder to perform the test. The paste washes out with shampoo and warm water.
6. Please do not take any naps on the day of your test. This will allow you to go to sleep easier when you are here in the lab.
7. Your test will end between 6:00 and 7:00 am, and you will be able to leave shortly after. If you need to be up before this time, please let your technologist know.

If would like to see our facility prior to your test or if you have any questions regarding your test, please contact the center at (321) 255-9901.



Space Coast Sleep Disorders Center
Patient Information

PLEASE COMPLETE ALL LINES **TODAY'S DATE: _____**

NAME: MR/MRS/MISS _____ MARITAL STATUS: M S D W

ADDRESS: _____

CITY: _____ STATE: _____ZIP _____

HOME PHONE: _____ CELL: _____

DATE OF BIRTH: _____ SOCIAL SEC. # _____-_____-_____

EMAIL ADDRESS: _____

EMPLOYER: _____ WORK PHONE: _____

EMPLOYER ADDRESS: _____

REFERRED BY: _____

NAME OF SPOUSE: _____

SPOUSE'S EMPLOYER AND ADDRESS:

_____

IN CASE OF EMERGENCY, PLEASE CONTACT: NAME _____

PHONE: _____

INSURANCE INFORMATION: WE WILL NEED A COPY OF YOUR CARDS

Primary Card Holder Information or Subscriber of Insurance: Relationship to Insurer:_____

NAME: _____
ADDRESS: _____
PHONE: _____DOB:_____SS:_____

(WE ACCEPT DEBIT CARDS, MASTER CARD, VISA AND DISCOVER)

*** IF PAYING WITH CASH, PLEASE BRING THE EXACT AMOUNT, OUR TECHNICIANS DO NOT CARRY CHANGE.**

Primary Insurance _____
Claims Address _____
City:_____ State_____ Zip_____

Secondary Insurance _____
Claims Address_____
City_____State_____Zip_____

LIFETIME AUTHORIZATIONS
PLEASE READ THIS CAREFULLY AND SIGN

1) I authorize the release of any medical information necessary to process my claim. I also request payment of benefits to the party who accepts assignment. I understand that even though I have insurance, I am responsible for any unpaid deductible, co-payment or co-insurance.

2) Depending on your insurance, there may be two co-payments or co-insurances associated with each sleep study.
    a. The technical fee will be billed by the facility for performing the sleep study.
    b. The professional fee will be billed by the sleep specialist interpreting the sleep study.

3) Space Coast Sleep Disorders Center accepts assignment on all Medicare patients. I understand that I am financially responsible for paying all deductibles. I understand that the 20% co-payment not covered by Medicare, or the co-payment not covered by private insurance is expected on the day services are rendered. In case of financial hardship or difficulty, a financial arrangement must be made prior to initiation of treatment.

4) Space Coast Sleep Disorders Center will be responsible for preservation and retention of medical records for seven years and for a three year period following the closure of the clinic.

5) Our office will file all primary and secondary insurance claims for our patients.

6) By signing below you have indicated that you have read the aforementioned insurance disclosure and agree to comply with the policy set forth by our office. In the event that we don not receive payment for services rendered and your account is submitted to a collection agency, there will be a 20% surcharge applied to your account.

Responsible party if the patient is under 18:
Name:_____
SSN:_____ DOB:_____
Address (If not the same as patient):
_____
_____
_____

_____ _____
***Signature* of Patient or Responsible Party** **Date**

Space Coast Sleep Disorders Center

Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our Practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name: _____

_____

***Signature* of Patient or Responsible Party**

Date: _____

Witness: _____

Space Coast Sleep Disorders Center

640 Classic Court Suite 106 Melbourne, FL 32940
Ph: 321-255-9901 / Fax: 321-255-9902
Email: info@spacecoastsleep.com

RELEASE OF MEDICAL RECORDS

I, _____, (Patient) DOB:_____

give Space Coast Sleep Disorders Center permission to release the results of my Sleep Study

to the following physicians:

1_____

2_____

3_____

4_____

_____ _____

Patient Signature or Responsible Party Date

_____ _____

Witness Date

* Space Coast Sleep Disorders Center shall be responsible for preservation and retention of medical records for a three-year period following the closure of the clinic.

Space Coast Sleep Disorders Center

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Email: info@spacecoastsleep.com

CONSENT TO PHOTOGRAPH AND/OR AUDIO-VIDEOTAPE

I, _____, authorize the taking of

Patient (Parent or Guardian)

photographs and or/or audio-videotape(s) by SDCDS with the understanding that such photographs and/or video tapes may be used for educational purposes or in the event of legal action. The Lab is hereby released without recourse from any liability arising from the taking and use of such photographs or video.

I also assign the right for SCSDC to copy the materials in whole or part. Any use of the tape for medical education will not identify me

☐ Check here if you do NOT authorize use for educational purposes.

_____ _____
Signature Patient or (parent or guardian) Date

_____ _____
Witness Date

CONSENT FOR POLYSOMNOGRAPHY

Details
A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

- Brain waves
- Heart rate
- Breathing rate
- Snoring
- Oxygen level
- Eye movements
- Chin movement
- Leg movements

The study also may involve other sensors. The sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you.

Risks
In order to conduct the sleep study, your technologist will be required to place electrodes and sensors to your body. To minimize the spread of COVID-19, your technologist will be required to wear gloves, a mask and face shield. The patient will be required to wear a surgical mask as well.

Agreement
My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technician will attach sensors to my body for the study.
3. The removal of the sensors in the morning may irritate my skin and cause redness.
4. A video camera will record me as I sleep. A technician will monitor my sleep from the control room.
5. I will be free to roll over and move in bed during the study.
6. I will need to ask for help if I must get out of bed for any reason.
7. The technician may need to enter the room to wake me if there is a problem.
8. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
9. I understand why I am taking this sleep study.
10. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.

_____ _____

Signature (Patient or Guardian) **Date**

_____ _____

Signature (Witness) **Date**