## Dear

You have been scheduled for an overnight sleep study on\_\_\_\_\_\_\_\_\_\_\_\_ at pm. Before you come to your appointment, please take few minutes to read the information.

Please feel free to contact us with any questions or concerns at (626) 572-8388.

|  |  |  |
| --- | --- | --- |
| **CANCELLATION:**  A private sleep room has been reserved for you and a sleep specialist has been scheduled to conduct your sleep study. If you are Unable to keep the scheduled Appointment please Notify us 24hours prior to avoid Cancellation fee of $150.00. | **INSURANCE:**  Most insurance carriers cover the procedure; however, it is important for you to understand that you are responsible for any  or all of the allowable charges. In the event your insurance company does not cover the total charge or a portion of the charge for your sleep evaluation,  it will be your responsibility to pay the full or remaining balance. | **RESULTS:**  The results for your test will be sent to your referring physician within10(Ten) business days.  Please contact your physician to schedule a follow-up appointment to discuss the  findings of the sleep study . |
| **TRANSPORTATION:**  Comfort Sleep provides Transportation with 5 miles of our clinic, for Patients that are in need of it. Test usually last for 6 to 8hours. | **SPECIAL NEEDS:**  The technicians that perform the sleep studies can only give limited care. If a patient has special needs, it is important to have someone stay with the patient during the night of the study. If a caregiver needs to stay with the patient, please tell us when scheduling your sleep study. | **TRANSLATORS:**  If the patient does not speak English someone needs to come with them to their appointment to translate the instructions to the patient. This generally takes about 45 minutes, however, sometimes the translator will need to spend the night in order to help communicate with the patient during the night. |

**The Day of Your Study**

* Please bring this completed packet of paperwork. Along with your insurance cards and a picture I.D.
* Please bring pajamas, favorite pillows, books, toiletries, or anything else you think will make your stay more comfortable (no pets). If you are not sure if you can bring a certain item, please give us a call prior to coming in for your appointment.
* Please arrive at your scheduled appointment time, please call us at 626-572-8388 if you are running late.
* Please do not take any naps and caffeine after 12.00pm.
* Please make sure your hair and skin is clean and dry. Please do not use any products in your hair or skin.
* Please take or bring all daily medications you take, but avoid taking sleeping pills until you arrive if you take them.
* Once you arrive technician will welcome you, take necessary paperwork, check your ID etc and explain you the procedure.
* Depending on the test, your test will be completed between 4am to 6am. If your test is completed by 4am, and you would like to stay till 6am, please let the technician know.

Note:

Alhambra Clinic directions

Patients that are scheduled in the Alhambra Clinic enter parking lot through Palm Ave and Clinic is located on the third floor suite 303.

Wilshire Clinic Directions

Patients that are scheduled at the Wilshire location enter guest parking through Ingramham street, pull forward towards the gate and it will automatically open. We do not validate; parking is about $25 for overnight. (only accept card) Street parking is free.

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**Patient Demographics Form**

**Patient Information (Please fill out completely)**

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number:

### Gender: Male Female

Marital Status: Single a Married

Divorced Other

Home Address (Number and Street):

City:

State:

Zip:

Home Number: Mobile Number:

Employer: Employer Number: Emergency Contact: Emergency Phone Number:

Relationship to the patient: Self Spouse Other, Please explain:

**Physician Information**

Primary Care Physician: PCP Phone Number:

PCP Address:

Referring Physician:

Referring Drs Number:

Referring Physician’s Address:

**Insurance Information**

Primary Insurance: Member ID Number:

Customer Service Number: Group Number:

Policy Holder’s / Subscriber’s Name: Date of Birth:

Relationship to the patient: Self

Spouse

Other, Please explain:

Secondary Insurance: Member ID Number:

Customer Service Number:

Group Number:

Policy Holder’s / Subscriber’s Name: Date of Birth:

Relationship to the patient: Self

Spouse

Other, Please explain:

FINANCIAL POLICY

Welcome to Comfort Sleep, and thank you for choosing us. We have adopted the following statement as our financial policy which we require that you read, agree to and sign prior to receiving any services,

Payment Responsibility: You are financially responsible for charges associated with your visit. As a courtesy, and for your convenience, we bill your insurance company for the services you receive. However, you are responsible for any and all annual deductibles and co-payments. Furthermore, not all insurance companies cover the services a t 100%, depending

on your insurance plan, you could be responsible for a portion of the charges. Different insurances pay different rates for the study which makes it difficult for us to quote how much you may be charged out of pocket. If you are uncertain of your coverage, please contact your insurance. If your insurance denies the claim you are personally responsible the balance owed on the account. It you choose not to Bill your insurance for services provided, lt is understood that you assume financial responsibility for all charges.

Methods of Payment: We accept cash, Pay Pal, Visa, MasterCard, Discover, and AMEX as payment for our services.

Patient Billing: Patients with outstanding balances are billed monthly. All payments are due 30 days from the billing date on the invoice. If the account balance has not been paid within 30 days, and you have not contacted the office regarding the account, your account may be referred to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to our professional collection company. All costs incurred in the collection process shall be added to the original balance due.

Missed Appointments: Please remember that a technologist and a private room have been reserved specifically for you on your scheduled appointment. You may be charged a fee $150.00 if you do not show up for your scheduled appointment, or if you don’t call 24 hours in advance during normal business hours of 8:30 am to 5:00 pm M-F cancel your appointment.

HIPPA: Your privacy important is to us. We ask that you please read over our HIPPA form, When you sign below›, you state that you have read and understand everything about HPPA. You may obtain a personal copy of our HIPPA form by requesting it from our office.

Video/Audio: Please note that video recording and audio monitoring are used during the study.

I, the undersigned, have read, clearly understand and *agree* to the provisions of this financial policy. I also authorized the release of any medical information necessary to process the claim and request, from my insurance carrier, payment of benefits to Comfort Sleep Clinic, for the services rendered. I also authorize Comfort Sleep Clinic to release any information that the collection company may need to collect any outstanding debt. I also authorize Comfort Sleep, LLC to release any information necessary for my treatment. •

Print name of the Patient

Signature of Patient or Guardian

Date

Guardian Relationship to Patient

**History and Physical**

Patient’s Name: Date of Birth: Gender: Chief Sleep Complaint:

### Past Medical History:

Please answer all of the following to the best of your ability.

Height: Weight: Neck Size: Race (optional):

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma |  | Yes |  | No | Heartburn (GE Reflux) |  | Yes |  | No |
| Back Problems |  | Yes |  | No | High Blood Pressure |  | Yes |  | No |
| Cancer |  | Yes |  | No | Lung Disease |  | Yes |  | No |
| Congestive Heart Failure (CHF) |  | Yes |  | No | Parkinson’s Disease |  | Yes |  | No |
| COPD |  | Yes |  | No | Psychiatric Disorder |  | Yes |  | No |
| Deviated Septum |  | Yes |  | No | Seizure |  | Yes |  | No |
| Diabetes |  | Yes |  | No | Shortness of Breath |  | Yes |  | No |
| Diagnosed Depression |  | Yes |  | No | Sinus Problems |  | Yes |  | No |
| Emphysema |  | Yes |  | No | Sore Throat |  | Yes |  | No |
| Frequent or Severe Headaches |  | Yes |  | No | Stroke |  | Yes |  | No |
| Heart Disease |  | Yes |  | No | Tuberculosis (TB) |  | Yes |  | No |
| HIV/AIDS |  | Yes |  | No | Weight Gain /Weight Loss |  | Yes |  | No |

**Medications:**

Please list any over-the-counter and prescription medications you are taking. If you need more space, attach a separate page. Medication Name: Dosage Times per Day

**Allergies: (including latex allergy)**

**Medical Equipment:**

Do you have or currently use and of the following:

CPAP Machine? NO YES If yes, then for how long?

BIPAP Machine NO YES If yes, then for how long?

**Sleepiness Scale:**

How likely are you to doze off or fail sleep in the following situations, in contrast to, just feeling tired?

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Sitting and reading:

Watching television:

Sitting inactive in a public place (i.e., a theater or meeting):

As a passenger in car for en 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

**Sleep Assessment:**

The following questions will help us to obtain a better understanding of your sleeping problems. Try to answer these questions as completely as possible. There are some questions that your bed partner or room-mate can be helpful with, such as those about snoring. All answers should reflect the past six months of your sleep, unless otherwise specified.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do you usually read or watch TV before going to bed? No Yes For how long? Hours or Minutes  Do you use any sleep aids or medications? No Yes How often? \_\_\_\_\_\_\_\_\_\_\_  Please list the medications used: How many hours of sleep so you get on average? Hours \_\_\_\_\_\_\_\_\_\_\_\_\_Minutes  How often do you wake up: For the restroom? Other? How long are you out of bed for? Hours \_\_\_\_\_\_\_\_\_\_\_\_\_ Minutes  How long does it usually take to fall back asleep? Hours \_\_\_\_\_\_ Minutes | | | | | | |
| Do you sleep in a reclining chair, elevated |  | Yes | No | Do you have the sensations of Paresthesia | Yes | No |
| bed, or a special surface? |  |  |  | (pins and needles) in your limbs at night? |  |  |
| Do you have disturbed or restless sleep? |  | Yes | no | Do you sweat excessively at night? | Yes | No |
| Do you sleep with someone else in your room? |  | Yes | no | Do you sleep walk? | Yes | No |
| Do you sleep with someone else in your bed? |  | Yes | no | Do you sleep talk? | Yes | No |
| Do you disturb the sleep of your sleep partner? |  | Yes | no | Do you feel muscular tension at night? | Yes | No |
| Do you have nasal congestion at night7 |  | Yes | no | Do you grind or clench your teeth at night? | Yes | No |
| Do you use a nasal spray or medication to deal |  | Yes | no | Do you awaken with the urgent need to | Yes | No |
| with nasal congestion? |  |  |  | urinate? |  |  |
| Do you have leg twitching or jerking during your |  | Yes | no | Do you have stomach or abdominal pains at | Yes | No |
| sleep? |  |  |  | night\* |  |  |
| Do you have thoughts racing through your mind or feel anxious when trying to sleep? |  | Yes | no | Do you awaken with acid reflux (severe Burning in your throat)? | Yes | No |
| Do you experience pain or discomfort at night? |  | Yes | no | Do you eat during the night? | Yes | Nc |
| Do you have itching sensations at night? |  | Yes | no | Do you have gas or indigestion at night? | Yes | No |
| Are you afraid you will not be able to sleep? |  | Yes | No | Do you feel sad or depressed at night? | Yes | No |