Patient Registration

Patient Information

Name Last	First	Middle	Martial Status S M D W
Address	City	State/Zip	Date of Birth
Social Security #	Sex M F	Primary Physician/Location	
Home Phone	Cell Phone	Email Address	
Employer	Occupation	May we contact you at work? Bus. Phone # Yes No	
Spouse's Name	Spouse DOB		
Person to Notify in Case of Emergency	Address/Phone #		Relationship

Responsible Party (if the patient is under 18 years of age or if someone other than the patient is responsible for the bill)

Name	Address	City	State/Zip Code
Home Phone #	Occupation	Employer	Relationship

Referral Information (help us track our success in advertising)

How did you hear about us? *(check all that apply)*

- ☐ My Healthcare Provider
- ☐ Phonebook
- ☐ Billboard
- ☐ Internet Search
- ☐ Radio _____
- ☐ Spouse
- ☐ Friend or other relative
- ☐ Health Fair Event
- ☐ Drove by building
- ☐ Other: _____

Consent for Contact

Authorization to contact

I agree to be contacted via email and/or text message for the purpose of appointment reminders only. Center for Sleep will not use this information for solicitation or other means of communication. Yes No

Consent for Care and Treatment, Civility Clause, Release of Information & Financial Responsibility

Consent for Care and Treatment: I, the undersigned, do hereby agree and give my consent for Center for Sleep to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her condition. This should be valid throughout all treatment for this condition.

Civility Clause: I agree to work together in a professional and business-like manner with the clinic staff to promote mutual respect, civility, and orderly conduct while being a patient at the facility. The clinic will in-turn respect my rights and treat me professionally and courteously while in their care.

Assignment of Benefits – Release of Information: I hereby assign all medical benefits to which I am entitled, from Medicare, Medicaid, private insurance and third party payors, to Center for Sleep. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Although we are providers for many insurance carriers, we CANNOT GUARANTEE PAYMENT OR COVERAGE of services. If you would like to know details regarding payment under your specific insurance plan, please contact your insurance provider.

The undersigned promises to pay all costs incurred in the collection of any, and all indebtedness due to Center for Sleep or one of his/her family members receiving healthcare services at Center for Sleep.

_____ _____

Patient Signature Date

NORTH DAKOTA Center for Sleep

Age: _____
Height: _____ Neck size: _____
Weight: _____ Weight 5 years ago: _____
Primary Care Physician: _____

MEDICAL HISTORY

Please check all that apply

□ Diabetes □ High Blood Pressure
□ Asthma □ Emphysema/COPD
□ Thyroid Disease □ Kidney Disease
□ Stroke □ Migraines
□ Heart Disease □ Irregular Rhythm
□ Depression □ Seizures
□ Gastric Reflux □ Congestive Heart Failure
□ Fibromyalgia □ Rhinitis/Sinusitis
□ Angina □ Claustrophobia/Anxiety
□ Head Injury: _____ When? _____
□ Others: _____

SURGICAL HISTORY

Please list all surgeries, with dates:

□ Tonsils/Adenoids
□ Heart Angiogram/Stents
□ Sinus/Nasal Surgery
□ Heart Surgery
□ Others: _____

EPWORTH SLEEPINESS SCALE

0 = NEVER doze off
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Would you doze off while:	*Scale Rating*
Sitting and Reading	
Watching TV	
Sitting inactive in public place	
As a passenger in a car	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped in traffic	
TOTAL	

SOCIAL HISTORY

□ Single □ Married □ Partner
□ Divorced □ Widowed (Significant other)

Do you have children? _____ How Old? _____

What kind of work do you do?

_____

Do you have a Commercial Driver's License
□ Yes □ No

SOCIAL EXPOSURES

Did you ever smoke? □ Yes □ No
How many packs/day? _____
Started at what age? _____
At what age did you quit? _____

Do you drink alcohol? □ Yes □ No
How much? _____
What time of day? _____
Do you consider yourself an alcoholic? □ Yes □ No

Do you consume caffeine? □ Yes □ No
□ Coffee □ Pop □ Energy Drinks
How much? _____

Did you use illicit substances? □ Yes □ No
□ Meth □ Marijuana □ Others: _____
How much? _____

FAMILY HISTORY

My Mother is: □ Alive □ Deceased
What age? _____

Health problems: _____

My Father is: □ Alive □ Deceased
What age? _____
Health problems: _____

_____

Any family history of:
□ Cancer □ Heart Disease □ Stroke
□ Seizures □ Sleep Apnea □ Insomnia
□ Others: _____

SLEEP HISTORY

Please complete the following

What time do you go to bed? _____
On days off: _____

How long before you fall asleep? _____

How many times do you wake up during the night?

How many times do you go to the bathroom during the night? _____

What time do you get out of bed in the morning?

On days off: _____

Use an Alarm Clock? □ Yes □ No

What time do you have to get to work?

Do you nap? □ Yes □ No How long? _____
Do you doze off? □ Yes □ No
What time of day? _____

Anyone share your bed? □ Yes □ No
Do you sleep better on vacation (away from home?)
□ Yes □ No
Please explain _____

Do you exercise? □ Yes □ No
What kind? _____
What time of day? _____

Previous sleep disorder diagnosed? □ Yes □ No
When? _____ What? _____
Treatment? _____

ALLERGIES

Any Drug Allergies? □ Yes □ No
Please list: _____

SLEEP HISTORY

Please check all that apply

□ Driving accidents or near accidents due to sleepiness
□ Significant weight gain
□ Snore
□ Awaken with choking sensation
□ Breath-holding spells

□ Trouble falling asleep
□ Trouble remaining asleep
□ Awaken with intense anxiety
□ Feel depressed during the day

□ Legs jerk and kick during sleep
□ Uncomfortable leg sensations that improve with movement
□ Uncomfortable leg sensations always worsening in the evenings

□ Jaw aches in the morning
□ Grind teeth in sleep
□ Sleep Talking as an adult
□ Sleep Walking as an adult
□ Acting out your dreams
□ Nighttime seizures
□ Shift Work

□ Awaken with back pain
□ Awaken with headaches
□ Awaken with heartburn or acid reflux
□ Awaken with cough or shortness of breath

□ Vivid dreams or hallucinations while awake
□ Paralysis or inability to move upon awakening
□ Sudden feeling of weakness in legs or knees

MEDICATIONS

Current Medication	Dose	Reason

Use back if more space needed

NAME: _____ DATE: _____

DOB: _____ Height: _____ Weight: _____ BMI: _____

Currently using CPAP: (circle one) Yes No

OSA Risk Assessment

Please answer the following questions, as they best describe you.

Do you snore loudly or often? (Described as louder than talking or loud enough to be heard through closed doors)	Yes	No
Are you often tired, fatigued, or sleepy during the day?	Yes	No
Have you been told you stop breathing during sleep?	Yes	No
Do you have OR are you being treated for high blood pressure?	Yes	No
Is your neck size > 17" (males) OR > 16" (females)?	Yes	No
Do you have diabetes?	Yes	No
Do you typically wake up or urinate one or more times during the night?	Yes	No
Do you have reflux?	Yes	No

TOTAL: _____

Patient Label

For Office Use Only

Epworth Score: _____ RA Score: _____

RDI: _____ AHI: _____

REV 2.8.2012

Acknowledgement of Notice of Privacy Practices

I acknowledge that Precision Diagnostic Services, Inc. has informed me of their Privacy Practices. I understand this form means only that I have reviewed the Notice and in no way affects the care I receive at Precision Diagnostic Services. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Date *Signature of Patient or Authorized Representative*

Office Use Only

TO BE COMPLETED BY PDS IF NO ACKNOWLEDGEMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgement from the patient or the patient's authorized representative. The good faith efforts made, and the reason acknowledgement could not be obtained were:

[ ] Patient (or authorized representative) refused to sign after being requested to do so.

[ ] Other: (please describe)

Date *Signature 0/ PDS personnel*

Printed name 0/ PDS personnel

HIPAA NOTICE OF PRIVACY PRACTICES

THIS HIPAA NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, IT ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS MEDICAL INFORMATION, PLEASE READ IT CAREFULLY,

HOWWE (INCLUDING OUR AFFILIATED ENTITIES) MAY USE OR SHARE YOUR PHI

We are committed to protect the privacy of your Protected Health Information (PHI), and we use and disclose It only as permitted or required by state and federal laws, We use and disclose your PH! for the purpose of providing healthcare services to you, receiving payment for our services, helping us to give you good quality healthcare, and other uses required by law, In this Notice, we give you examples of how we may use your PHI. We cannot list every use or disclosure, but all uses and disclosures of your PHI fall within one of the categories described in this Notice,

Treatment. We use and share your PHI with physicians, technicians, students, and other healthcare personnel to provide you trealment or services, This includes the coordination or management of your healthcare with third parties. For example, if you are referred to a physician. we may share your PHI with that physician, to make sure that he/she has the necessary information to diagnose or treat you. We may also use your PHI contact you to check the status of your equipment and supplies.

Payment. We use and disclose your PHI to obtain payment for our healthcare services. This may include disclosure to other providers so they may receive payment for their services, For example, to get approval for equipment or supplies, we will disclose your PHI to an insurance company or other third party to obtain approval for coverage. We also provide your PHI to our business associates or other providers' business associates, such as billing companies, transcriptionists, collection agencies, and vendors who mail billing statements, These business associates are given only enough information to provide the necessary service related to your healthcare.

Healthcare Operations. We use or disclose your PHI (or a portion of it) to support our goal of providing you with good quality healthcare services. For example, we may use your PHI to evaluate the quality of healthcare services that you received, to evaluate the performance of the healthcare professionals who provided services to you, for medical review purposes, or auditing,

We May Be Required to Use or Disclose Your PHI without your Authorization,

The law sometimes requires us to use or disclose your PHI without your authorization, including:

Notification and Communication with Family. Unless you object, we may release your PHI to a relative, close friend, personal representative, or any other person you identify, The PHI we release directly relates to that person's involvement in your healthcare, or that person's help in paying for your heahhcare. If you are unable to provide written authorization (agreeing or objecting to the release), we may release PHI if we determine that it is in your best interest based on our professional judgment, such as emergency situations. We may also use or share your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and releases to family or other individuals involved in your healthcare. We may use postcards to communicate with you regarding your appointments.

Required by Law, Court or Law Enforcement. We may release your PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence, when dealing with crime, or when ordered by a court,

Public Health. As required or permitted by law, we may release your PHI to public health authorities for purposes related to preventing or controlling disease, injury or disability, which includes reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure,

Health Oversight Activities, We may release your PHI to health agencies for activities authorized by law. These oversight activities include audits, investigations, and inspections as necessary for our licensure and for the government to monitor the healthcare system, government programs and compliance with civil rights laws, For example, we may release your PHI to the Secretary of the Department of Health and Human Services so they can determine our compliance with privacy laws.

Deceased Person Information, We may release your PHI to coroners, medical examiners, and funeral directors,

Organ Donation, We may release your PHI to organizations involved in procuring, banking, or transplanting organs and tissues

Public Safety. We may disclose your PHI to appropriate persons to prevent or lessen a serious and near threat to the health or safety of a particular person or the general public.

Specific Government Functions, We may disclose your PHI for military or national security purposes, or in certain cases, if you are in law enforcement custody.

Workers' Compensation. We may disclose your PHI as necessary to comply with workers' compensation laws, We report any injuries referred to us from an employer to your state's Department of Workers' Compensation and any work-related deaths to Occupational Safety and Health Administration ("OSHA"). All employers are given PHI regarding work-related injuries Ihey have referred to us.

Appointment Reminders and Health·Related Benefits, We may use your PHI to contact you to provide appointment reminders.

Business Associates-we may use or disclose your PHI to "business associates" who perform healthcare or bHlingoperations for us and who commit to respect the privacy of your PHI,

Fundraising, Marketing and the Sale of PHI. We will not sell your PHI or use or disclose it for marketing purposes without your specific permission, We do not participate in fundraising activities: if we begin, we will modify this Notice to give your rights,

Treatment of Sensitive Information. Your PHI that is psychotherapy noles and diagnostic and therapeutic information regarding rnenlal health, drug/alcohol abuse or sexually transmitted diseases (including HIV status) will not be disclosed without your specific permission, unless required or permitted by law.

Other permitted and required uses and disclosures, Other uses and disclosures including state and federal law requirements, will be made only with your consent, authorization or opportunity to object unless 8 law requires us to use or disclose your PHI. You may revoke your authorization, at any time, in wriling, and your revocation will apply to future uses or disclosures of your PHI.

YOUR RIGHTS ABOUT YOUR PHI

Inspect and Copy. You have the right to inspect and copy your PHI. You may receive a paper and/or electronic copy of your PHI. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to a law that prohibits access to PHI.

Request Limits. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or heallhcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except as follows: You have a right to request a restriction on certain disclosures to your health plan if the disclosure is solely for carrying out payment or healthcare operations, and you have fully paid out-of-pocket for the services.

Communication. You have the right to request to receive confidential communications from us by alternative means or at an alternative location (for example, by mail rather than by phone). You must make these requests in writing. We will comply so long as *vie* can easily do that in the formal you requested.

Corrections. You may have the right to ask us to amend your PHI. You must make this request in writing. We are not required to change: your PHI. If we deny your request, we will provide you with information on how to disagree with our denial.

Disclosures. You have a right to request a list of disclosures we have made ot your PHI. The request must be in writing and must be for a specific period of time (which may be limited by state law). We do not have to account *for* the disclosures described under treatment. payment, healthcare operations, information provided to you, information released incident to an allowed disclosure (see Incidental Disclosures section in this Notice), information released based on your written authorization, directory listings, information released for certain government functions, disclosures of a limited data set (which may only include date information and limited address information). or disclosures to correctional institutions or law enforcement in custodial situations.

Incidental Disclosures. We make reasonable efforts to avoid incidental disclosures of your PHI. An example of an incidental disclosure is conversations that may be overheard between you and our staff at one of our facilities.

Paper Copy of Notice. You have the right to obtain a paper copy at this Notice, upon request.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint at (770) 855-7677. We will not retaliate against you for filing a complaint.

Changes to This Notice. We reserve the right to change the terms of this Notice. We will post our current Notice on our websites. You have the right to object or withdraw your authorization about your PH! as provided in the Notice.

Affiliated Entities.
Preferred Diagnostic Centers, LLC
Sleep Services of America, Inc
MedBridge Home Medical LLC
Precision Diagnostic Services Inc
Sleep Easy Therapeutics, Inc.
SleepWorks, LLC
PSC Sleep Centers, LLC
Ogles Oxygen, LLC
Sleep Therapy, LLC
CPAP Solutions, LLC
Southeast Sleep, lLC

Your signature on the Palient Service Agreement acknowledges that you have received a copy of this Notice of our Privacy Practices.

If you have questions about any pari of this notice or if you want more information about our privacy practices, contact our Privacy Officer.

Effective Date: March 20, 2016

Do you have billing questions?

If you received a consultation with **Seema Khosla, MD**
then your billing/insurance is done through:

Center for Sleep, LLC
4152 30th Avenue South, Suite 103 **B**
Fargo, ND 58104

Questions? call Lara in the billing department at (701) 356-3000 or (877) 757-2796

If you received a sleep study at the **North Dakota Center for Sleep**
then your billing/insurance is done through:

Precision Diagnostic Services, Inc./Medbridge Heathcare
4152 30th Avenue South, Suite 103
Fargo, ND 58104

Questions? call the PDS billing department at (877) 550-2949