SLEEP SCIENCE CLINICS (TEXAS)

7215 WYOMING SPRINGS, STE. 600, ROUND ROCK TX 78681
800 BRAZOS STREET, STE. 1400, AUSTIN TX 78701
TEL: 512.255.2727 FAX: 512.255.6277

PATIENT REGISTRATION
AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patient's Name	**Sex** ☐ M ☐ F	**Birth Date** _____/_____/_____	**Marital Status** ☐ Single ☐ Widowed	☐ Married ☐ Divorced

Patient's Address:	**City:**	**State:** **Zip:**

Home Phone:	**Cell Phone:**	**Patient's Social Security No.**

If employed, Name of Employer:	**Business Phone:**
Employer's Address if applicable:	**Occupation:**

Person Financially Responsible ☐ Self ☐ Name:	**Relationship** ☐ Spouse ☐ Other	**Resp Party's Birth date** _____/_____/_____	**Resp's Social Security No.** **Resp's Phone No.**

Reason for Visit: ☐ PT ☐ ENG ☐ Sleep Study ☐ Other: _____	**Referring Physician:**	
	Person to Contact in Case of Emergency:	
	Relationship to Patient:	**Emergency Phone Number:**

Primary Insurance (ID Card to be photocopied):	**Secondary Insurance (ID Card to be photocopied):**

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefits to Sleep Science Clinics, LLC. for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures

I specifically agree to pay finance charge of 1.5% per month (18% per annum) on any balance due over 90 days, and specifically agree to attorney's fees of 25% or greater, as well as all to collection, court costs and interest fees accrued with the collection of this account.

Further, I have received copies and read Sleep Science Clinics, LLC Financial and Payment Policy and Notice of Privacy Practices.

_____ _____

Patient, Parent or Guardian Signature (If patient is under 18 years old) **Date**

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SLEEP QUESTIONNAIRE

NAME: _____ ____ _____
FIRST NAME MI LAST NAME

DOB (mm/dd/yy): _____ Age: _____ Gender: Male ☐ Female ☐

Height: _____ Feet: _____ Inches: _____ Neck Size: _____

Tally Risk Points

Neck Size
+2 Male ≥ 16.5
+2 Female ≥ 15.0

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION- ANSWER ALL QUESTIONS

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	Yes ○ No ○	Stroke	Yes ○ No ○		
Heart Disease	Yes ○ No ○	Depression	Yes ○ No ○		
Diabetes	Yes ○ No ○	Sleep Apnea	Yes ○ No ○		
Lung Disease	Yes ○ No ○	Nasal Oxygen Use	Yes ○ No ○		
Insomnia	Yes ○ No ○	Restless Leg Syndrome	Yes ○ No ○		
Narcolepsy	Yes ○ No ○	Morning Headaches	Yes ○ No ○		
Sleeping Medication	Yes ○ No ○	Pain Medication e.g., Vicodin, Oxycontin	Yes ○ No ○		

Co-morbidities
+1for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

0 =would never doze **1 = slight chance of dozing**
2 = moderate chance of dozing **3 = high chance of dozing**

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (theater, meeting, etc.)				
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 lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Epworth Score TOTAL the values from all 8 questions,
If 11 or less **Score= 0**
If 12 or more **Score= 2**

Score ☐

Assign points for each of the first three responses

Frequency: **0–1 times/week** **1–2 times/week** **3–4 times/week** **5–7 times/week**

On average in the past month, how often have you snored or been told that you snored? ☐

Never☐ Rarely☐ + 1 Sometimes☐ + 2 Frequently☐ +3 Almost always☐ +4

Do you wake up choking or gasping? ☐

Never☐ Rarely☐ + 1 Sometimes☐ + 2 Frequently☐ +3 Almost always☐ +4

Have you been told that you stop breathing in your sleep or wake up choking or gasping? ☐

Never☐ Rarely☐ + 1 Sometimes☐ + 2 Frequently☐ +3 Almost always☐ +4

Do you have problems keeping your legs still at night or need to move them to feel comfortable? ☐

Never☐ Rarely☐ + 1 Sometimes☐ + 2 Frequently☐ +3 Almost always☐ +4

Signature	(Area Code) Phone Number	**Total all 6 boxes from above**	**POINT TOTAL**
		If point total = 4 to 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	☐

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DURABLE ASSIGNMENT OF BENEFITS
AND
PAYMENT AUTHORIZATION

Date: _____

Insurance(s): _(A photo copy of your insurance card should be attached with this document)_

Subject: Patient Name: _____

DOB: _____

To Whom It May Concern:

I, _____, authorize payment of medical service(s) to the provider, Sleep Science Clinics LLC, Inc or all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Please mail check payable to:

SLEEP SCIENCE CLINICS, LLC
7215 Wyoming Springs, Suite 600
Round Rock, Texas 78681

Thank you.

Effective Date of Authorization: _____ _____
(Signature)

_____
(Print Name)

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Patient Name: _____ Patient DOB: _____

I hereby acknowledge that I have read and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms on this form by affixing my initials.

1. **Medical Treatment**
   I do hereby consent to be tested at Sleep Science Clinics, LLC. and permit my physician, his/her technician to perform any service or routine diagnostic procedure which the physician deem necessary. I acknowledge that no guarantees have been made as to the result of the tests or examinations in the sleep lab. I also understand that it is possible that this procedure may result in mild and temporary skin irritation. In very rare circumstances skin discoloration can occur.

2. **Release of Information**
   I hereby authorize Sleep Science Clinics, LLC to release part or all of my medical records to other Medical professions, and/or any insurance company, governmental agency managed care organization, or any other entity or person who may be required to pay all or part of the costs of my treatment and/or outpatient care.

3. **Authorize to Video Tape**
   I authorize Sleep Science Clinics, LLC to videotape me during my sleep diagnostic study to facilitate an accurate diagnosis as to the type and severity of any sleep disorder and that all such tapes will be held in the strictest confidence and shared only with medical professionals responsible for my medical care. I understand that I will receive no compensation, whatsoever from any party for permitting such filming.

4. **Assignment of Benefits and Financial Policy**
   Insurance plans with co-insurance/co-pay are the responsibility of the patient and is collected before every treatment is performed.

5. **Personal Valuables**
   I understand that Sleep Science Clinic, LLC, its trustees, officers, employees are not responsible for loss of, or damage to, property that is kept by me in the sleep lab. I am fully responsible for all articles, jewelry, dentures, eyeglasses, etc. and clothing that I retain in my possession (in the room) and for any other articles that may be brought to me while I am a patient in the Sleep Science Clinics, LLC.

6. **Privacy Practices**
   I acknowledge receipt of Notice of Privacy Practices.

Patient's Signature _____ **Date** _____

_____
(Print)

Witness _____ **Date** _____

_____
(Print)

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Patient Name: _____ Date of Birth: _____

Date of Service: _____

New Patient Visit

Indicate whether you have ever had any of the following and if so, please describe:

Abnormal swelling in legs or feet	Yes ____ No ____
Pain in calves when you walk	Yes ____ No ____
Awakening at night short of breath	Yes ____ No ____
Arthritis and Rheumatism	Yes ____ No ____
AIDS or HIV	Yes ____ No ____
Blackouts or loss of consciousness	Yes ____ No ____
Cardiac Arrhythmias	Yes ____ No ____
Chest Pain	Yes ____ No ____
Congestive heart failure	Yes ____ No ____
Diabetes	Yes ____ No ____
Hiatal hernia or reflux esophagitis	Yes ____ No ____
High blood pressure	Yes ____ No ____
Heart attack	Yes ____ No ____
High/Low blood sugar	Yes ____ No ____
Lung Disease	Yes ____ No ____
Pain, Stiffness or swelling in back, muscles	Yes ____ No ____
Problems falling asleep, staying sleep	Yes ____ No ____
Rapid or irregular heartbeats	Yes ____ No ____
Thyroid disease	Yes ____ No ____
Significant Headaches	Yes ____ No ____
Skin rash	Yes ____ No ____
Daytime sleepiness	Yes ____ No ____
Sleep apnea, snoring	Yes ____ No ____
Weight loss or gain of more than 100lbs	Yes ____ No ____

Current Medications: _____

_____

Have you ever had a sleep study performed? Yes ____ No ____
If yes, where and what were the results?

_____

_____