



# 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 <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date ____/____/____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Name: _____		Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Resp Party's Birth date ____/____/____	Resp's Social Security No.	
				Resp's Phone No.	
Reason for Visit: <input type="checkbox"/> PT <input type="checkbox"/> ENG <input type="checkbox"/> Sleep Study <input type="checkbox"/> 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 <input type="radio"/>	No <input type="radio"/>	Stroke	Yes <input type="radio"/>	No <input type="radio"/>
Heart Disease	Yes <input type="radio"/>	No <input type="radio"/>	Depression	Yes <input type="radio"/>	No <input type="radio"/>
Diabetes	Yes <input type="radio"/>	No <input type="radio"/>	Sleep Apnea	Yes <input type="radio"/>	No <input type="radio"/>
Lung Disease	Yes <input type="radio"/>	No <input type="radio"/>	Nasal Oxygen Use	Yes <input type="radio"/>	No <input type="radio"/>
Insomnia	Yes <input type="radio"/>	No <input type="radio"/>	Restless Leg Syndrome	Yes <input type="radio"/>	No <input type="radio"/>
Narcolepsy	Yes <input type="radio"/>	No <input type="radio"/>	Morning Headaches	Yes <input type="radio"/>	No <input type="radio"/>
Sleeping Medication	Yes <input type="radio"/>	No <input type="radio"/>	Pain Medication e.g., Vicodin, Oxycontin	Yes <input type="radio"/>	No <input type="radio"/>

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)

	<b>0 = would never doze</b>	<b>1 = slight chance of dozing</b>	<b>2 = moderate chance of dozing</b>	<b>3 = high chance of dozing</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
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	<b>Total all 6 boxes from above</b> if point total = 4 to 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)	<b>POINT TOTAL</b> <input type="text"/>
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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, HSTs, PAP 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. 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.

### 4. 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.

### 5. Privacy Practices

I acknowledge receipt of Notice of Privacy Practices.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

(Print)

Witness \_\_\_\_\_

Date \_\_\_\_\_

(Print)