

PATIENT INFORMATION

Patient Name: _____ Pt Sex: _____ Birthday _____
Address: _____ Apt #: _____ Marital Status: _____
City & State: _____ Zip: _____
Home Phone # () - _____ Cell Phone # () - _____
Work Phone # () - _____ Ext: _____
E-Mail Address: _____
Pharmacy Name: _____
Main Cross Streets: _____
Pharmacy Phone # () - _____ Fax # () - _____
Social Security #: _____
Drivers License #: _____ State: _____
Employer: _____
Employer Address: _____
Emergency Contact: _____ Phone # _____
Relationship to Patient: _____

GAURANTOR INFORMATION – IF DIFFERENT FROM ABOVE

Guarantor Name: _____ Relationship to Pt: _____
Address: _____ Apt #: _____ Marital Status: _____
City, State, Zip: _____ Home Phone # () _____
Employer: _____ Phone # () _____
Employer Address: _____
Guarantor Social Security #: _____ Birthday: _____ Sex: _____

INSURANCE INFORMATION

PRIMARY

Insurance Co Name: _____ Employer of Policy Holder: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Insurance Claim Address: _____
Insurance Claim Phone # _____ Policy Holder Birthdate: _____ Sex: _____
Insurance ID # _____ Group # _____ Effective Date: _____

Secondary Insurance Co Name: _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to The Dallas Center for Sleep Disorders. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance and I hereby authorize said assignee to release all information necessary to secure payment.

*****PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED*****

Signed: _____ **Date:** _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment. Dr. Kakar and the providers of Dallas Sleep render only services that, in their professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE

We accept cash, Discover, American Express, Visa, or Mastercard

REGARDING INSURANCE:

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your medical expenses with us.

- The patient is responsible to pay any deductible and co-payments prior to or at the time services are rendered.*
- It is your responsibility to know if a referral is necessary for your visit.*
- Any portion of a billed amount that is labeled "not allowed" or "not covered" will be the patient's responsibility. This is not the contractual obligation amount the physician will discount due to the practice's relationship with your insurance plan.*
- Our office NEVER guarantees that your insurance will pay, or that they will pay what they quoted our benefits team. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.*
- If your insurance has not processed and paid your claim within 6 months, you will be responsible for the balance on your account.*
- Your insurance is a contract between you and the insurance company. We are not party to that contract. While we have an agreement with the Plan to provide services, any questions regarding coverage must be resolved by you with your insurance company.*

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.

NSF CHECKS

All returned checks will assess a \$30.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.

Thank you for understanding our financial policy and the necessity of explaining this in writing to our patients. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the provisions of this financial policy.

Signature of patient or responsible party if patient is a minor

Date

The Dallas Center for Sleep Disorders HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a durable medical equipment company that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval or authorization.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing or conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

Acknowledgement of Review of Notice of Privacy Practices

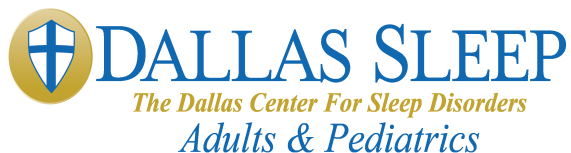
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Name of Personal Representative

Date

Description of Personal Representative



Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse _____

Child(ren) _____

Other _____

Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call my home my work my cell: _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

NO SHOW AND CANCELLATIONS

Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours notice for office appointments and Sleep Studies, you will be billed:

\$35 for clinic appointments

\$250 for Sleep Study appointments

Please note that calls must be received during our regular business hours. Our hours are Monday – Friday, from 8 am to 5 pm.

Please know that your insurance company does not cover this charge. Repeated “no show” appointments could result in referring you back to your insurance company for reassignment to another specialist.

I understand that the office will make every attempt to place a reminder call for my appointments. However, whether or not a confirmation call is placed, I am still held responsible for remembering my appointment day and time.

Signature of Patient

Date

Printed Name of Patient

Adult New Patient Registration & Medical Background Information

Ph: 972.473.7300 | Fax: 972-473-7750
6313 Preston Rd., Ste 400, Plano, TX 75024

PATIENT INFORMATION

Name _____ DOB ____ / ____ / ____

CHIEF COMPLAINT: _____

SLEEP HISTORY

Lights Out: _____ AM PM

Lights On: _____ AM PM

Number of awakenings during the night: _____

Trips to the bathroom during the night: _____

Do you take any sleep aids to help you sleep? Yes No

If yes, what kind? _____

Do you have a history of any of the following? (Check if "YES" to any of the following)

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty falling asleep at night | <input type="checkbox"/> Sleep talking | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Acting out dreams | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Gasping/choking during sleep | <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Hypertension/high blood pressure |
| <input type="checkbox"/> Sweating/perspiring in sleep | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Depressed mood/irritability |
| <input type="checkbox"/> Drooling in sleep | <input type="checkbox"/> GERD/reflux/heartburn | <input type="checkbox"/> Anxiety/stressed out |
| <input type="checkbox"/> Dry mouth upon awakening | <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Difficulty with concentration |
| <input type="checkbox"/> Teeth grinding/clenching | <input type="checkbox"/> Tired/fatigued during the daytime | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Excessive movements in sleep | <input type="checkbox"/> Nasal allergies/hay fever/nasal congestion | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Nightmares/bad dreams | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest pain/chest discomfort |
| <input type="checkbox"/> Sleep walking | <input type="checkbox"/> TMJ pain/jaw discomfort | <input type="checkbox"/> Shortness of breath during the day |

PAST MEDICAL HISTORY

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

PAST SURGICAL HISTORY

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
|----------|----------|

Have you ever had your tonsils and/or adenoids surgically removed? Yes No

MEDICATIONS (including prescription and over-the-counter)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

ALLERGY HISTORY (to any medications or substances)

None Known YES, to: 1. _____ 1. _____
3. _____

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day _____ # of cups or glasses of tea per day
_____ # of cans or glasses of soda per day _____ # of servings of chocolate *per week*

Alcohol: None Yes _____ # of drinks per day, _____ # of days *per week*

Tobacco: None Yes _____ # of packs per day, _____ # of years

Recreational Drugs (such as marijuana or cocaine): None Yes

If yes, which ones? _____

Marital Status: Married Single Divorced Widowed **Occupation:** _____

Children: No Yes How many? _____ **Pets:** No Yes How many? _____

Do you have any children or pets that sleep in your bedroom? No Yes

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if "yes" to all that apply):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic insomnia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Overweight/obesity | <input type="checkbox"/> Restless legs syndrome | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Snoring | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Sleep apnea | | |

Thank You.

REVIEW OF SYMPTOMS (ROS)

Constitutional:

Loss of Appetite: Yes No
Sweats: Yes No
Fever: Yes No
Fatigue: Yes No
Weight Gain: Yes No
Weight Loss: Yes No

Gastrointestinal:

Heartburn/Indigestion: Yes No
Black or Bloody Stools: Yes No
Diarrhea: Yes No
Nausea/Vomiting: Yes No
Jaundice: Yes No
Abdominal Pain: Yes No

Allergy/Immunology:

Sneezing: Yes No
Runny Nose: Yes No
Itchy Eyes or Nose: Yes No
Hives: Yes No

Eyes:

Blurry Vision: Yes No
Double Vision: Yes No
Vision Loss: Yes No

Cardiac:

Palpitations: Yes No
Chest Pain: Yes No
Daytime Shortness of Breath: Yes No
Nighttime Shortness of Breath: Yes No
Ankle Swelling: Yes No

Skin:

Unusual Moles: Yes No
Rash: Yes No
Dryness: Yes No

Endocrine:

Weight Gain: Yes No
Heat Intolerance: Yes No
Excessive Thirst: Yes No
Constipation: Yes No
Cold Intolerance: Yes No

Respiratory:

Cough: Yes No
Shortness of Breath: Yes No
Wheezing: Yes No
Poor Exercise Tolerance: Yes No

Genitourinary:

Bed Wetting: Yes No
Frequent Urination: Yes No
Difficulty Urinating: Yes No
Blood in Urine: Yes No

Musculoskeletal:

Stiff/Sore Joints: Yes No
Muscle Pain: Yes No
Red or Swollen Joints: Yes No

Ears/Nose/Throat/Mouth:

Hearing Loss: Yes No
Sore Throat: Yes No
Sinus Congestion: Yes No
Hoarseness: Yes No

Neurologic:

Weakness: Yes No
Seizures: Yes No
Involuntary Tongue Biting: Yes No
Passing Out: Yes No
Dizziness: Yes No
Headaches: Yes No
Numbness: Yes No

Hema/Lymph:

Unexplained Weight Loss: Yes No
Unusual Bleeding/Bruising: Yes No
Swollen Lymph Nodes: Yes No

Psych:

Excess Stress: Yes No
Memory Loss: Yes No
Difficulty with Focus,
or Concentration: Yes No
Hallucinations: Yes No
Nervousness or Anxiety: Yes No
Depressed Mood: Yes No

THE EPWORTH SLEEPINESS SCALE

Name: _____

Your Age (Years): _____

Your Sex (Please Circle): M F

Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 choose the most appropriate number for each situation:

- 0 – Would *never* doze
- 1 – *Slight* chance of dozing
- 2 – *Moderate* chance of dozing
- 3 – *High* chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (i.e. a theater or meeting)	_____
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 the car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation

Sleepiness and Driving

Excessive daytime sleepiness (EDS) is the result of many different problems and it can cause impaired human performance. We feel obligated to inform you about EDS because of its potential for increased accidents and injuries.

Driving while you are sleepy is dangerous. There are 100,000 – 200,000 automobile accidents in the US each year due to sleepiness and fatigue. These crashes cost the US economy \$12.5 billion, injure 71,000 individuals, and kill 1,500 people each year in the US alone. Sleep problems and EDS lead to 4 – 7 times the normal risk of having an auto or truck accident. Obviously, it is dangerous to be sleepy in any situation that requires complete alertness.

We recommend that you drive only when fully alert. If you become drowsy while driving, you should pull off the road safely and stop driving. Return to driving only when you are clearly awake. Some people find that a brief nap, a brisk walk, or a cup of coffee will help them become more alert.

There are significant legal and social obligations associated with the safe operation of your motor vehicle. You need to inform us if you are unable to follow our recommendations regarding driving and sleepiness.

Share this information with a friend and you may save his or her life.

Please sign and date below indicating that you have read and understand this information.

Signature of Patient

Date

Printed Name of Patient