Neuro Diagnostic Sleep Centers

Name: _____ DOB: ____ _____ Date:_____

Symptoms	X	Sleep Habits	Time
Loud snoring		At what time do you usually get in the bed?	
Breathing or snoring stops in my sleep		How long does it take you to fall asleep after you have turned out the lights?	
Awaken gasping for breath		How often do you awaken each night?	
Become sleepy during the day		Total time I spend awake in bed?	
Difficulty falling asleep		I usually wake up from sleep at?	
Difficulty remaining asleep		What time do you get out of bed from sleep?	
Awaken too early		Indicate total length of naps daily?	
My mind races with many thoughts when I try to fall asleep		If you do rotating shift work, or have other work schedule changes and need more space to describe?	
I often worry whether or not I will be able to fall asleep		**Epworth Sleepiness Scale**	
Fatigue			
Awaken with a dry mouth			
Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up		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	
Irritability/ Depression			
Memory impairment or Inability to concentrate		**Situation**	**Score**
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep		Sitting and reading	
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep		Watching TV	
Pain which delays, prevents, or awakens me from sleep		Sitting, inactive, in a public place(e.g., a theater or a meeting)	
Inability to move as you are trying to go to sleep or wake up		As a passenger in a car for an hour without a break	
Morning headaches		Lying down to rest in the afternoon	
Sudden weakness or feel your body go limp when you are angry or excited		Sitting and talking with someone	
Irresistible urge to move legs or arms		Sitting quietly after a lunch without alcohol	
Creeping or crawling sensation in your legs before falling asleep		In a car, while stopped for a few minutes in traffic	
Legs or arms jerking during sleep			
Frequent urination disrupting sleep		**Total***	
Sleep talking or Sleep walking		*Greater than 10 indicates sleepiness	

Neuro Diagnostic Sleep Centers

Patient Name: _____ DOB: _____ / _____ / _____

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT APPLY

CARDIAC	Chest Pain		Murmur(s)		Palpitation(s)	
CONSTITUTIONAL	Fatigue		Fever		Sleep Disorders	
	Weight Gain		Weight Loss			
EARS,NOSE,THROAT	Difficulty Swallowing		Hearing Aids		Ringing In Ears	
	Ear Pain		Hearing Loss			
ENDOCRINE	Diabetes		Thyroid			
EYES	Blurred Vision		Double Vision		Eye Pain	
GASTROINTESTINAL	Abdominal Pain		Constipation		Heartburn/Reflux	
	Bowel Incontinence		Diarrhea		Vomiting	
HEMATOLOGIC	Anemia		Easy Bruising			
INFECTIOUS	AIDS / HIV		Scabies		Tuberculosis	
	Hepatitis		Sexually Transmitted Disease(s)			
MUSCULOSKELETAL	Joint Pain		Muscle Pain		Other	
NEUROLOGICAL	Difficulty with Speech		Fainting/Black Out		Numbness	
	Difficulty Using Hands		Headache(s)		Seizures	
	Difficulty Walking		Memory Loss		Tingling	
	Dizziness		Muscle Weakness		Tremors	
PSYCHIATRIC	Anxiety		Bi-Polar Disorder		Depression	
RESPIRATORY	Asthma		Chronic Cough		Shortness of Breathe	
UROLOGIC	Kidney Stones		Painful Urination			
	Prostate Disorder		Urinary Hesitation			

SOCIAL HISTORY: Please answer all questions below

Do you smoke? ☐ NO ☐ YES ☐ Cigarettes ☐ Cigars ☐ Pipe How often/How long? _____

Do you drink alcohol? ☐ NO ☐ YES ☐ Beer ☐ Wine ☐ Liquor / Mixed drinks How often? _____

Do you use street drugs? ☐ NO ☐ YES What Type(s)? _____How often? _____

Employment ☐ Employed ☐ Retired ☐ Not working at this time.

Are you married? ☐ NO ☐ YES ☐ Divorced ☐ Separated

Medical Provider Signature: _____ Date: _____/ _____/ _____

Neuro Diagnostic Sleep Centers

Date: _____/ _____/ _____

Patient Name: _____

DOB: _____ /_____ /_____

<u>MEDICATIONS:</u> PLEASE LIST THE NAME(S) AND DOSAGE(S) OF ALL MEDICATIONS YOU CURRENTLY TAKE.

Check here for ☐ NO Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

<u>ALLERGIES:</u> PLEASE LIST ALL ALLERGENS AND YOUR REACTION TO THEM.

Check here for ☐ NO Allergies

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you currently take any medication to fall asleep? ☐ NO ☐ YES what type? _____ how long? _____

Have you ever used sleep medications? ☐ NO ☐ YES what type? _____ how long? _____

<u>Have you had a sleep study done in the past?</u> ☐ NO ☐ YES If yes, when? _____

<u>PAST MEDICAL HISTORY:</u>

Do you now or have you ever had:		
❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

NeuroDiagnostic Laboratories

Appointment DATE: _____ / _____ / _____

Patient Name: _____ **Date of Birth**: _____ /_____ / _____

Patient S.S. #: _____ - _____ - _____ **Gender**: **M / F** **Marital Status**: Single / Married / Divorced / Widow

Patient Address:_____ # _____

City: _____ **State**: _____ **Zip Code**: _____

Home ( ) _____ - _____ **Work** ( ) _____ - _____ **Cell** ( ) _____ - _____

In Case of Emergency Contact

***Name**: _____ **Relationship**: _____ Phone: ( ) _____ - _____

Primary Care Physician: _____ Phone: ( ) _____ - _____

Was a current insurance card presented for today's appointment? Y / N

If YES – no additional information is needed

If NO – please complete the fields below

Primary Insurance:

Carrier: _____ Group# _____ Plan ID: _____

Guarantor Name (if not self): _____ Relationship: _____

Guarantor Date of Birth: _____ / _____ / _____ SS# _____ - _____ - _____

Secondary Insurance:

Carrier: _____ Group# _____ Plan ID: _____

Guarantor Name (if not self): _____ Relationship: _____

Guarantor Date of Birth: _____ / _____ / _____ SS# _____ - _____ - _____

Worker's Comp: ☐ Y ☐ N Auto Accident: ☐ Y ☐ N Date of Injury: _____ / _____ / _____

W/C Office: _____ Claim #: _____

SLEEP CONSULTATION CONSENT

I have been referred to American Medical Diagnostics (AMDx, Ltd.) | NeuroDiagnostic Laboratories and Sleep Centers (NDL, LLC) for a sleep consultation, to determine if I am a candidate for a sleep study. If it is determined that I am an eligible candidate for a sleep study, related service(s) will be scheduled and rendered at a later date.

I understand that the physician will be asking me a series of questions regarding my current condition in order to complete an evaluation and recommend possible treatment options.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP CONSULTATION

Patient Name (printed): _____**Patient Signature**: _____

If the patient is a minor, please print the name of the patient's representative:

_____, Relationship to the Minor _____

Representative Signature: _____

FINANCIAL POLICY

As a courtesy to our patients, our facility will provide the service of billing your insurance carrier. However, practical benefits are not determined until a claim is received by your insurance company. When requested, our group can provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, an initial payment equal to no less than one half (1/2) of the total cost for the ordered test(s) is due at the time service is rendered. Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. (dba: NeuroDiagnostic Laboratories, LLC).

A Non-sufficient Funds (NSF) Fee of $25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd, (dba: NeuroDiagnostic Laboratories, LLC) and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment and coverage for services and/or supplies provided to me by AMDx, Ltd (dba: NeuroDiagnostic Laboratories, LLC).

AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF

I further authorize AMDx, Ltd., (dba: NeuroDiagnostic Laboratories, LLC) and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare, if I am a Medicare beneficiary. I understand that in the even of an adverse decision made by my insurance carrier as it relates to coverage, authorization or payment(s), AMDx, Ltd., (dba: NeuroDiagnostic Laboratories, LLC) is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

Date: _____ / _____ / _____

Patient Name (printed): _____**Patient Signature**: _____

If the patient is a minor, please print the name of the patient's representative:

_____, Relationship to the Minor _____

Representative Signature: _____

NeuroDiagnostic Sleep Centers

RECEIPT OF PRIVACY PRACTICE NOTICE

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories, LLC (NDL, LLC) Notice of Privacy Practices.

AMDx, Ltd. and NDL, LLC maintain strict compliance with the Health Information and Patient Portability Act (HIPPA) and the guidelines set therein.

Should you have questions regarding the information provided in the AMDx, Ltd. /NDL, LLC Notice of Privacy Practices, please advise the patient reception hostess and/or the AMDx, Ltd. /NDL, LLC. Patient Privacy Officer, as indicated on the notice you received.

I HAVE BEEN PROVIDED, READ AND UNDERSTAND MY RIGHTS UNDER THE PATIENT PRIVACY PRACTICES.

Patient Name (printed): _____**Patient Signature**: _____

If the patient is a minor, please print the name of the patient's representative:

_____, Relationship to the Minor _____

Representative Signature: _____

NeuroDiagnostic Sleep Centers

Sleep Consult Cancelation Policy

Our goal is to provide quality individualized medical care in a timely manner. In order to be respectful of the medical needs of other patients, please be courteous and call NeuroDiagnostic Sleep Center promptly if you are unable to attend your appointment. If it is necessary to cancel your scheduled appointment, we require that you call and speak with our scheduling department at least 24 hours in advance.

A "no-show" is someone who misses an appointment without notice or does not provide at least 24 hour notice of cancelation. Each no show appointment you will be charged $50.00.

*Further documentation may be required in the event your appointment is canceled outside of the policy guidelines.

Please arrive at least 15 minutes prior to your scheduled appointment.

Thanks you for your understanding and cooperation with the outlined policy.

NeruoDiagnostic Sleep Center
Phone: 602-424-4450
Fax: 602-424-4451