FLAGLER DIAGNOSTIC & SLEEP DISORDER CENTERS
TJC and AHCA Accredited

1001 W. Cypress Creek Rd, Suite 104
Ft. Lauderdale, FL 33309
Phone: (954) 306-3760 | Fax: (877) 537-8123

# DO'S AND DON'T'S ON THE DAY OF YOUR SLEEP STUDY

- **NO CAFFIENATED** beverages or products after 10:00 A.M. (Soda, Coffee, Tea, Energy Supplements, etc.)
- **NO ALCOHOL**.
- **NO SMOKING** after 5:00 P.M.
- **IF YOU ARE A PAP USER AND ARE BEING RE-ASSESED FOR THE CONTINUED PRESENCE OF SLEEP APNEA DISCONTINUE PAP USE 3 NIGHTS PRIOR TO EXAM. This will ensure no false negatives. PLEASE BRING YOUR MASK WITH YOU.**
- All medications are to be taken as scheduled. Anything that would impair ability to drive should be taken at the facility. You will be instructed by the technician when to take your medication.
- WASH and DRY HAIR, no gels, mousse, hair spray, braids, scalp covers or sew-in hair. Products will not allow electrodes to stick to scalp.
- **NO LOTIONS, CREAMS, OILS, OR MAKE-UP ON SKIN OR FACE.**
- Wear minimum jewelry.
- **WEAR LOOSE, TWO PIECE SLEEPING OUTFIT** (pajamas or shorts and t-shirt).
- **Please bring slippers or socks.**
- Cell phones must be turned **OFF** when lights are out and during the study.
- You may bring a favorite pillow/blanket or personal toiletries.

Your appointment is at 8:30 PM. Our lab doors will open at 8:15 PM SHARP.

YOU CAN EXPECT TO LEAVE NO LATER THAN 5:00 A.M. THE FOLLOWING MORNING.

***We REQUIRE A 48 HOUR NOTICE OF CANCELLATION to avoid a $300 Cancellation Fee.**

If you have any questions, please feel free to call!
We look forward to helping your doctor evaluate your sleeping needs.

PLEASE RETURN THIS COMPLETED PACKET TO US ON THE NIGHT OF YOUR SLEEP STUDY, ALONG WITH A LIST OF YOUR CURRENT MEDICATIONS

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## PATIENT INFORMATION

Last Name_____ First_____ MI_____

Sex: **M** **F** DOB:_____ SSN:_____

Height:_____ Weight:_____ BMI:_____

Address:_____

City_____ State_____ Zip_____

Home Phone:_____ Cell:_____

Email:_____

## EMERGENCY CONTACT

Name_____ Relationship_____

Home Phone_____ Cell_____

## INSURANCE INFORMATION

Primary_____

Secondary _____

Tertiary_____

Policy Holder_____ Relationship_____ Subscriber DOB _____

**Referring Physician**_____

**Primary Care Physician**_____

**Pulmonologist**_____

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Briefly describe your sleep problems:

_____

_____

_____

Current Medications (include OTC and dosage information)

_____

_____

_____

Have you ever had sleep testing or been diagnosed with **Sleep Apnea?** _____

Prescribed or attempted treatments_____

Do you snore? **Yes__ No__ Unsure__** Is it positional? (lying on your back ect.) **Yes__ No__ Unsure __**

If yes describe your snoring _____

Can you breathe through your nose? **Yes___ No___** Both Nostrils? **Yes___ No___**

What is your normal Bedtime?_____

What is your normal Wake time?_____

| | | |
|---|---|---|
| Do you awaken with dry mouth or sore throat? | Y | N |
| Do you awake gasping for air or short of breath? | Y | N |
| Has anyone notice you quit breathing at night? | Y | N |
| Do you awaken with headaches? | Y | N |
| Have you been diagnosed with Emphysema or COPD? | Y | N |
| Do you have a history of Heart Failure or Heart Attack? | Y | N |
| Do you have a history of High Blood Pressure? | Y | N |
| Have you been diagnosed with any muscular weakness disorder? | Y | N |
| Do you kick or twitch your legs at night, prior to falling asleep? | Y | N |

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| | | |
|---|---|---|
| Do you have trouble keeping your legs still at night when relaxed? | Y | N |
| Do you get any aching or creeping sensations in your legs at night? | Y | N |
| Do you ever feel as if you were going to faint, blackout, or fall down? | Y | N |
| Have you had difficulty staying awake during the day? | Y | N |
| Have you been told you grind your teeth while sleeping? | Y | N |
| Have you awakened from sleep and been unable to move? | Y | N |
| Do you sweat at night even without being hot? | Y | N |

## PAST MEDICAL HISTORY

Name:_____Date_____

Have you ever experienced or been diagnosed with any of the following? Mark all that apply.

| | | | | | |
|---|---|---|---|---|---|
| Low Back Pain | | Asthma | | Malaise / Fatigue | |
| Neck Pain | | Diabetes | | Nausea / Vomiting | |
| Osteoarthritis | | Epilepsy | | Bowel Dysfunction | |
| Rheumatoid Arthritis | | Shortness of Breath | | Numbness | |
| Joint Replacement | | Pregnancy | | Weakness | |
| Metal Implants | | Cancer | | Dizziness | |
| Fractures | | Allergies | | Night Pain | |
| Sprains | | Deviated Septum | | History of Smoking | |
| Syncope / Fainting | | Urinary Changes | | Insomnia | |
| Headaches / Migraines | | Sexual Dysfunction | | Restless Leg Syndrome | |

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| | | | | | |
|---|---|---|---|---|---|
| Pacemaker | | Strains | | Substance Abuse | |
| Osteoporosis | | Indigestion | | Restrictive Lung Disease(s) | |
| Sleep Apnea | | Fever / Chills / Sweating | | COPD | |
| Congestive Heart Failure | | Periodic Limb Movement | | Weight Change | |

Please comment on any of the items marked above:

_____

_____

_____

_____

_____

Previous Surgeries / Hospitalizations / Significant Family History:

1. _____ Date_____
2. _____ Date_____
3. _____ Date_____
4. _____ Date_____
5. _____ Date_____
6. _____ Date_____

## PAST MEDICAL HISTORY

Name:_____ Date:_____

Has today been an unusual day in any respect? **Yes** **No**

If yes please explain:_____

How much sleep did you get last night? _____

Did you take a nap today? **Yes** **No**

If yes please explain:_____

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Please indicate below if you had alcohol, coffee, tea, or any caffeinated beverage today. Specify approximately what time and how much.

| TYPE | AMOUNT | TIME |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List any medications you took today include prescription and OTC medications, if you brought your medication list with you please indicate below.

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
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# PAST MEDICAL HISTORY

Do you have any physical complaints or ailments right now? **Yes** **No**

If yes please explain:_____

Mark below the best statement(s) that best describe how you are feeling right now:

| | | | | | |
|---|---|---|---|---|---|
| Active and Vital | | Alert and Wide Awake | | Anxious | |
| Able to Concentrate | | Sleep Onset Soon | | Functioning, Not Able to Focus | |
| Trance | | Struggling to Stay Awake | | Relaxed but Awake | |

Please comment on the marked responses:

_____

_____

Are you currently using Home Medical Equipment? (Oxygen, PAP, Wheelchair etc.) **Yes** **No**

If yes, who is your Medical Supply Company? _____

**EPWORTH SLEEPINESS SCORE**

**Rate the chance that you would doze off or fall asleep in the following situations:**

| | |
|---|---|
| **0= No chance of dozing off** | **2= Moderate chance of dozing off** |
| **1= Slight chance of dozing off** | **3= High chance of dozing off** |

| | |
|---|---|
| Sitting and reading | |
| Watching television | |
| Sitting inactive in a public place | |
| As a passenger in a car riding 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 (you being the driver) | |

**Total Score:**

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**Total Score:**

# FINANCIAL LIABILITY

Name:_____ Date:_____

SSN:_____ Date of Birth:_____

I, for myself or for the patient name above do herby consent and authorize the:

( ) Baseline Sleep Study ( ) CPAP/ BIPAP Titration ( ) Split Night ( ) MSLT ( ) HST

Ordering Physician:_____

1. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of the test(S) or procedure(s) listed above.
2. I understand that in the event of a medical emergency my physician will be contacted. If immediate medical care is needed the county EMS will be summoned and I will be transported to the nearest Emergency Facility.
3. I am aware that the Sleep Center is not responsible for any lost/ forgotten personal items.
4. I am aware that I will be financially responsible for any co-payments, deductible or charges NOT covered by my insurance.
5. If I provide the wrong insurance information at the time of service, I will be billed the full amount of study, If my correct insurance will not cover the charges.
6. Please arrive on time. Sleep disorders can be serious; to treat your problem(s) your doctor requires the test to be administered in a timely manner. These tests are costly not only in time, but also expertise.
7. For home sleep tests, there will be a separate fee of $50 for device preparation and instruction. This is separate from insurance coverage
8. Any payments made by credit card will be subject to a 2.5% convenience fee. Payments may be made by check or cash to avoid the surcharge.

**A CANCELLATION WITHOUT 48 HOURS NOTICE PRIOR TO YOUR TESTING WILL INCUR A SUBJECTIVE FACILITY CHARGE OF $300.00**

_____ _____

**Patient Signature** **Witness Signature**

**Patient is unable to sign due to him/ her being a minor (_____) years of age.**

Other reason (please specify) _____

_____ _____

**Guardian Signature** **Witness Signature**

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**New patient consent to the use, disclosure and acknowledgement of health information for treatment, payment or health care operations**

I, _____ understand that as a part of my health care, Flagler Diagnostic & Sleep Disorder Center originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, and test results, diagnosis', treatment and any plans of future treatment. I understand that this information serves as;

- A basis for planning my care and treatment
- A means of communication amongst the health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify services billed were provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a **Notice of Information Practices,** in the office policies that provides a more complete description of information uses and disclosure. I understand that I have the following rights and privileges;

- The right to review the notice prior to signing
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Flagler Diagnostic and Sleep is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that Flagler Diagnostic and Sleep Disorder Center reserves the right to change their notice and practices. Prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations, should Flagler Diagnostic and Sleep Disorder Center change their notice they will send me a copy of any revised notice to the address I have provided via US mail.

I further understand that as part of this facilities treatment, payment or health care operation, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I acknowledge that I am here to receive treatment for services provided by Flagler Diagnostic and Sleep Disorder Center, who has explained that all services rendered to me, will be billed to the insurance company for the services I received. In the event of a billing error, I may be entitled to a certain percentage of reduction in the amounts paid by the insurance company. If there is any such reduction, I acknowledge that authorization is not a guarantee of payment. If my insurance denies the claim for payment at no fault of Flagler Diagnostic and Sleep Disorder Center, I may be responsible for payment of the services. I further acknowledge that I will not be solicited by a person to seek any services from this provider.

I fully understand and accept the terms of this contract.

_____

Patients Signature Date

**For office use only**

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( ) Consent received by _____ on _____
( ) Consent refused by patient and treatment refused as permitted.

**Patient Bill of Rights**

The American Hospital Association developed "A Patients Bill of Rights" with the belief that it will add to more effective patient care and be supported by the hospital on behalf of the organization, its medical staff, employees and patients.

Health care involves a partnership between patients and doctors and other health care professionals. Open communication, respect for personal and professional standards, and understanding of differences are important for the best possible patient care. Hospitals should;

- Provide a base for understanding and respecting the rights and responsibilities of patients, their families, doctors and other caregivers
- Respect the role of patients in decision making about treatment choices and other care
- Be aware of cultural, racial, language, religious, age, gender, and other differences as well as the needs of a person with disabilities

Hospitals have many functions to preform, including treating injury and disease, health promotion and prevention, rehabilitation of patients, education of health professionals, patients, community and research. All these activities should be conducted with concern for the values and dignity of patients.

The following information was adapted from the American Hospital Association's "A Patients Bill of Rights". It is not a state law.

Another person chosen by the patient can exercise these rights on the patient's behalf. A proxy decision maker can exercise this right if the patient lacks decision-making ability, are legally incompetent or is a minor.

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from doctors and other direct caregivers appropriate, current and understandable information about diagnosis, treatment, and prognosis. Except in emergencies when the patient lacks decision-making ability and the need for treatment is urgent, the patient is entitled to the change to discuss and request information about the specific treatment(s) / procedure(s), the risks involved, the possible length of recuperation and the medically reasonable alternatives and their risks and benefits. Patients have the right to know the identity of doctors, nurses, and others involved in their care, as well as when those involved are students, patients, or other trainees. The patient also has the right to know the immediate and long term financial implications or treatment choices as they are known.
- The patient has the right to make decisions about the plan of care before and during treatment. The patient has the right to refuse a recommended treatment or plan of care to the extent allowed by law and hospital policy and to be informed of the medical consequences of this action. In case of refusal, the patient is entitled to other appropriate care and services the hospital provides or transfers to another hospital. The hospital should only notify patients of any policy that might affect patient choice within the institution.

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## CONTINUED

- The patient has a right to an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision maker with the expectation that the hospital will honor the intent of that directive to the extent permitted by the law and hospital policy. Health care institutions must inform patients of their rights under state law and hospital policy to make informed medical choices, ask if the patient has and advance directive, and include that information in patient records. The patient has a right to timely information about hospital policy that may limit its ability to implement fully a legally valid advance directive.
- The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.
- The patient has the right to expect that all communications and records related to his/her care will be treated as confidential by the hospital, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the hospital will stress the confidentiality of this information when it releases it to any other parties entitled to review information in these records.
- The patient has the right to review the records about his/her care and to have the information explained or interpreted as necessary, except when restricted by law.
- The patient has the right to expect that, within its capacity and policies, a hospital will make reasonable response to a patients request for appropriate and medically indicated services. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permitted, or when a patient has requested, a patient may be transferred to a different facility. The institution to which the patient is being transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.
- The patient has the right to ask and be informed of business relationships among the hospital, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.
- The patient has the right to consent to or decline to take part in research studies or human experimentation affecting care and treatment or requiring direct patient involvement, and to have those studies fully explained prior to consent. A patient who declines to take part in research or experimentation is entitled to the most effective care that the hospital can otherwise provide.
- The patient has a right to expect reasonable continuity of care when appropriate and to be informed by doctors and other caregivers of available and realistic patient care options when hospital care is no longer appropriate.
- The patient has the right to be informed of hospital policies and practices that relate to patient care, treatment and responsibilities, the patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. The patient has the right to be informed of the hospitals charges for the services and available payment methods.

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## CONTINUED

**Patient Responsibilities**

The partnership nature of health care requires that patients, or their families/ surrogates take part in their care. The effectiveness of care and patient satisfaction with the treatment depends, in part, on the patient fulfilling certain responsibilities. The following patient responsibilities are;

- Patients are responsible for providing information about past illnesses, hospitalizations, medications, and other matters related to health status. To participate effectively in decision making, patients are responsible for asking for additional information or explanation about their health status or treatment when they do not fully understand information and instructions.
- Patients are also responsible for ensuring that the health care institution or hospital has a copy if their advance directive if they have one.
- Patients are responsible for telling doctors and other caregivers if they expect problems in following prescribed treatment.
- Patients should be aware of the hospitals duty to be reasonably efficient and fair in providing care to other patients and the community. The hospitals rules and regulations are intended to help the hospital meet this responsibility. Patients and their families are responsible for making reasonable accommodations to the needs of the hospital, other patients, medical staff and hospital employees.
- Patients are responsible for giving necessary information for insurance claims and for working with the hospital to make payment arrangements when necessary.
- A person's health depends on much more than health care service. Patients are responsibly for recognizing the impact of their lifestyle on their personal health.

Reference: www.ahca.org

Patient Signature Date