New Patient Registration

New Patient Registration

1. First Name: Middle Initials: Last Name: Date of Birth:

Gender:
○ Female ○ Male
○ Prefer Not to Answer

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated
○ Divorced ○ Widowed

Street Address: Apt./Unit #: City: State: Zip Code:

Mobile Phone: Home Phone: Do you have a smart phone or tablet?
☐ Yes ☐ No

Work Phone: Email - Required for Telehealth

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

Social Security #: Driver's License #:

Referring Physician: Phone Number:

2. Responsible Party – If the Patient is a Minor

First Name: Middle Initials: Last Name: Date of Birth:

Street Address: Apt./Unit #: City: State: Zip Code:

Mobile Phone: Home Phone: Work Phone:

Email: Social Security #: Driver's License #:

3. Emergency Contact Information

Name Phone Number Relationship to Patient

4. Primary Insurance

Primary Insurance Company: Member ID / Policy #: Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name: Insured Phone #: Insured Date of Birth: Insured Gender:
○ Female ○ Male

Insured Street Address: Insured City: Insured State: Zip Code:

5. Secondary Insurance

Secondary Insurance Company: Member ID / Policy #: Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name: Insured Phone #: Insured Date of Birth: Insured Gender:
○ Female ○ Male

Insured Street Address: Insured City: Insured State: Zip Code:

6. Include Insurance Card (Front and Back) and Driver's License Photo

Health/Sleep History Questionnaire

7. Patient Name:

8. What is the primary reason for your visit (poor sleep, goals, review results, CPAP eval, etc)?:

9. Sleep Schedule

What time do you get into bed (range or average)?

How long does it take you to fall asleep?

How many times do you wake up in the night, even if just briefly?

What time do you wake up in the morning to start your day?

How many total hours of sleep do you get per day (average or range)?

Do you use any medications (Rx or over the counter) to help you sleep?
○ Yes ○ No

If so, what do you take?

Do you feel refreshed upon awakening?
○ Yes ○ No

Do you find yourself sleepy or fatigued during the day?
○ Yes ○ No

Have you ever had any car accidents due to feeling tired/fell asleep driving?
○ Yes ○ No

Favorite sleep position: Sides, Back, and/or Stomach?

10. Sleep Related Breathing Disorders

	Yes	No
Does anyone sleep next to you or in the same room as you currently?		
Have you ever been told that you snore?		
Do you ever stop breathing or have shallow or irregular breathing while sleeping?		
Do you ever wake up coughing, choking, gasping for air, or feel short of breath?		
Do you wake up with a headache?		

11. Sleep Studies, CPAP, or Oxygen

Have you ever had a Home Sleep Apnea Test, In-Lab Sleep Study, or Overnight Oxygen Test before?
○ Yes ○ No

If yes, what year was it performed, and what type of study, and are these results available?

12. Ever been diagnosed with sleep apnea?
○ Yes ○ No

If yes, fill out the rest of this table:

Are you a current CPAP user?
○ Yes ○ No

How long have you been on CPAP?

What pressures or levels do you use?

What DME Company do you use?

Serial # of CPAP?

Mask type (nasal, pillow, full face?)

_____

Do you like your current mask?
○ Yes ○ No

Do you have any DOT or FAA regulations to meet for CPAP compliance?
○ Yes ○ No

Are you a current oxygen user?
○ Yes ○ No

13. Restless Legs

	Yes	No
Do you have an urge to move your legs, or an unpleasant sensation in the legs?		
Do the sensations ever prevent you from falling asleep or wake you from sleep?		

14. Parasomnias

	Yes	No
Do you have any persistent nightmares that wake you from sleep?		
Ever been told you sleep walk?		
Ever been told you sleep talk?		
Ever been told that you acted out your dreams while sleeping (punching/kicking)		
Do you ever have visual or auditory hallucinations or lifelike visions as you fall asleep or wake up?		
Do you ever wake from sleep feeling paralyzed or unable to move?		
Do you ever experience sudden loss of muscle tone or sudden weakness during the day?		

15. Insomnia

	Yes	No
Do you often have issues falling or staying asleep, or waking earlier than intended?		

16. Hypersomnias

	Yes	No
Do you wake feeling rested/restored by sleep?		
Do you often find yourself feeling very tired or sleepy during the day?		

17. Epworth Sleepiness Scale How likely are you to doze or fall asleep in the following situations? 0: would never doze 1: slight chance of dozing 2: moderate chance of dozing 3: high chance of dozing

Situation	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (eg a theatre or a 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 with someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Medical History

18. Please check the box if you have any of the following medical conditions (current or have been diagnosed in the past). If you have a disorder that is not listed, please use the blank areas to let us know this diagnosis

- ☐ High blood pressure/hypertension
- ☐ High cholesterol or lipids (taking a statin)
- ☐ Heart Disease (heart attack/heart failure)
- ☐ Arrhythmias (afib, aflutter, PVCs/SVTs, etc)
- ☐ Lung Issues (asthma, COPD, diaphragm issues)
- ☐ Diabetes/Prediabetes
- ☐ Kidney disease
- ☐ Polycythemia or anemia (blood issues)
- ☐ Stroke/seizure/neurological disease/dementia
- ☐ GERD/Acid Reflux/Heart Burn
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ Chronic pain
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Hypothyroidism

Not listed:

_____

19. Do you have any ALLERGIES to any medications?

- ☐ I have no known allergies to any medications

_____

- ☐ I have allergies to the following medications:

_____

20. Please list any current/active MEDICATIONS you are taking that are prescribed to you (even if only "as needed"):

☐ I am not taking any prescription medications

_____

☐ I am currently taking the following medications and doses (list):

_____

21. Social History

Do you currently use any tobacco products, cigarettes, vaping, chew, nicotine, etc?
○ Yes ○ No

Have you ever used any tobacco products in the past?
○ Yes ○ No

For how long? _____

When did you quit? _____

How many alcoholic beverages do you have per week, on average?

_____

Do you drink any caffeine, such as tea, coffee, soda, or energy drinks/supplements?
○ Yes ○ No

How many per day? _____

Do you use any recreational drugs (such as marijuana, cocaine, etc)?
○ Yes ○ No

Do you have any history of alcohol/narcotic/benzo abuse, current or past?
○ Yes ○ No

22. What is your current height in inches? _____

What do you currently weigh in pounds? _____

What is your BMI? _____

What is your neck size? _____

What do you do for work? _____

What city to your currently live? _____

What is the approximate elevation of where you live?

_____

Modified Berlin Questionnaire

23. Date:

_____

Patient Name: _____

DOB: _____

Height (inches): _____

Weight (lbs): _____

Gender:
○ Male ○ Female

Please choose the correct response to each question.

24. Category 1

1. Do you snore?
○ a. Yes ○ b. No ○ c. Don't know

If you answered 'yes':

2. You snoring is:
○ a. Slightly louder than breathing ○ b. As loud as talking ○ c. Louder than talking

3. How often do you snore?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

4. Has your snoring ever bothered other people?
○ a. Yes ○ b. No ○ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

25. Category 2

6. How often do you feel tired or fatigued after your sleep?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
○ a. Yes ○ b. No

If you answered 'yes':

9. How often does this occur?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

26. Category 3

10. Do you have high blood pressure?
○ Yes ○ No ○ Don't know

Mountain
Sleep Diagnostics

Last Name **First Name** **DOB**

Authorize Direct Payment

I hereby authorize the payment of medical benefits directly to Mountain Sleep Diagnostics (MSD) and/or affiliates. Authorization is hereby granted to release information contained in the patient's medical record to the patient's insurance company (employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include the release of information regarding communicable diseases. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to MSD. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection agency expenses of MSD, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before any services are rendered.

Signature

Receipt of MSD Privacy Practices

I have received a copy of Mountain Sleep Diagnostics Privacy Practices, which can also be found at www.mountainsleepdiagnostics.com .

Signature

Contact Consent

You agree, by providing us with your phone number(s), you give express authorization to be contacted at that number, as well as authorize such contact by our agents and assigns. This express authorization also applies to any phone number(s) you may acquire in the future. We may also contact you by sending text messages, or emails, using any address you provide. Methods of contact may include using prerecorded/artificial voice messages and/or the use of an automatic dialing device, as applicable. Providing your phone number (s) is not a condition of receiving our services. I have read this disclosure and agree that we may be contacted as described above.

Disclosure of Information

I give Mountain Sleep Diagnostics and their staff permission to leave messages regarding my medical care with the following individuals:

____ Do Not Leave Messages or Speak to Anyone on my Behalf

Signature

Health Information Exchange

_____ OPT – In Check this box to opt into the Health Information Exchange service provided by MSD. This service allows the facility to pull your medical records from other participating facilities in the exchange network as well as share medical records with the exchange network. This service greatly reduces the time necessary to gather medical records and provides a more comprehensive healthcare experience for you.

_____

Signature

Other Fees and Financial Information

If you are insured, please provide our office with your current insurance ID card(s). If you do not have insurance, or you do not provide insurance information, payment in full shall be collected at the time of service. If you have a financial hardship, a payment plan can be arranged through our billing office. Please call ahead of your appointment.

As a courtesy, our office will bill your insurance(s) and do all the paperwork for you. Co-payments, deductibles, and any non-covered services (as detailed by your insurance plan) are due and payable at the time of your visit. At times, we make the best guess estimate on what your co-insurance/deductible might be. We might collect more, in which that money will be refunded. We might collect less, in which you will be responsible for the balance.

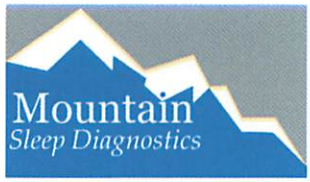
For In-Home Testing Patients Only – You are responsible for the unit to perform your In-Home testing. You may be billed the replacement cost for the unit if you do not return the unit in the same condition you received it. We provide the box and return postage for your use.

$20.00 - Non-Payment of Co-Pay	Charged in addition to co-pay if you do not pay at the time of service
$35.00 - Insurance Re-Bill	Charged if incorrect insurance is provided to the Practice at the time of service.
$25.00 - Returned Check Fee	Charged for all Non-Sufficient Fund checks returned from the bank.
$50.00 - No Show Fee	Charged if you do not show, or do not provide 48 hours cancellation notice.

_____

Signature

Informed Consent for Procedure/Treatment



In-Lab Services

Request for Provision of Service: I understand that by signing this consent, I indicate my intent to purchase health care services from Mountain Sleep Diagnostics, Inc **(MSD)** and hereby give permission to MSD and its agents to perform said testing.

Risks and Benefits: The risks and benefits of the procedure have been explained to me, as well as the risks and benefits of refusing the procedure. There are no known risks for a sleep study other than possible skin irritation due to the attachment of the device or the electrodes to the skin. The benefits of having a Polysomnogram are getting an accurate diagnosis of Sleep Apnea, and treatment if clinically warranted.

Possible Treatments: None, CPAP, BiPAP, ASV, Oxygen or any combination of these listed.

Consent for Video and Audio Taping: I hereby give my consent for videotaping, audio taping and/or photography for professional use in diagnosing and recommending treatment and/or teaching. I understand that my name will be kept confidential at all times, regardless of the use of these recordings. **Video and Audio Taping are not performed for In-Home Sleep Testing procedures.**

Medical Information Authorization: I hereby authorize my physician/hospital to furnish to an agent of MSD any records about my medical history, mental or physical condition, services rendered, or treatment needed to process claims.

Release of Medical Information to Insurance Carriers: I hereby authorize MSD to furnish to my insurance carrier(s) or its agent(s) any information concerning my medical history, mental or physical condition, services rendered or treatment need to process claims.

In-Home Units

Acknowledgment of Demonstration of Equipment Use: You will be either instructed in person, by video link, by phone and/or provided written instruction on how to apply the equipment and how the equipment operates for a successful study. If you have further questions regarding the use of the In-Home unit, please call our 24-hour Helpline at **303.956.5145.**

Acknowledgment for End of Year Policy: I acknowledge that because home sleep studies are performed without a technician present there is no assurance the test will be successful or meet the requirements needed. A repeat study may be needed. I am aware if testing must be repeated for any reason; I will be responsible for meeting the possible re-set of my deductible for any scheduling after the start of the New Year. I understand that MSD must bill my insurance for the day of the SUCCESSFUL study.

Acknowledgment for Responsibility of In-Home Unit: I acknowledge that I am responsible for the In-Home unit that has been provided for my care. If I damage or do not return the unit, I may be billed the replacement cost of the unit.

Clinic Patients

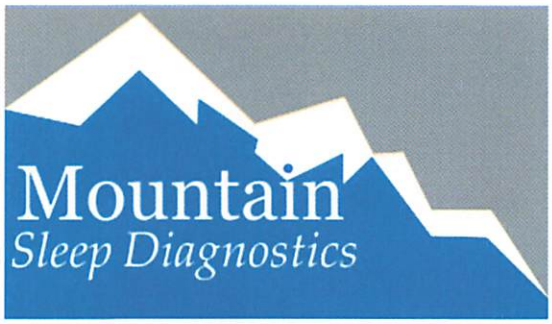
All of your clinic provider appointments are done using telehealth. There will be a Telehealth consent form presented for signature once your appointment has been scheduled. It will also explain how this service works.

Assignment of Insurance Benefits: I assign and transfer to MSD any and all rights to receive any insurance benefits otherwise payable to me for provided products or services. I authorize my insurance company to furnish to any agent of Mountain Sleep Incorporated any and all information pertaining to my insurance benefits and the status of claims required by my insurance program. I acknowledge that I am responsible for my co-payment, unmet deductible amount or other amount not covered by my insurance program.

I acknowledge that no guarantees, either express or implied, have been made to me regarding the outcome of any treatments and/or procedures. I understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or process.

_____

Signature



Send Completed Forms To

Mountain Sleep Diagnostics
191 Telluride Street
STE 5
Brighton, CO 80601