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Colorado Springs Welcome Packet

1849 Austin Bluffs Parkway • Colorado Springs, CO 80918

Fax: (303) 957-5414 Phone: (303) 802-0841 Email: Office@mountainsleepdiagnostics.com

Consultations

Dear Consult Patient,

You have been scheduled for a consult at 1849 Austin Bluffs Parkway Colorado Springs CO 80918.

Please fill out the attached form and bring it with you along with your insurance card and a photo ID. Please also bring a list of all medications.

You will be seeing one of our Nurse Practitioners for your sleep consult or follow up visit.

Consult appointments are 45-60 minutes long and follow up visits are 15-30 minutes long.

- You must confirm your appointment with us. We do reminder calls for your appointment 3 days prior and 1 day prior.
- If you are late for your appointment you may be required to reschedule.
- If you no-show for your first consult appointment, we will notify your Doctor and you no longer will be seen in our office.
- If you no-show for your follow up visit you will be given the opportunity to reschedule one time with an appointment deposit of \$65 which is non-refundable. If you no-show again we will not be able to see you in our clinic.
- Co-pays are due at time of service.
- If you are on CPAP therapy, please bring your CPAP machine, charging cord, and machine chip with you to each appointment.
- This is a specialty office visit and not part of your sleep study fees.

Please call us if any scheduling conflicts should arise. We do require 72-hour notice if you should need to cancel. If less than that is given, you could be subject to a \$65 cancellation fee.

Thank you,

Jordan Camden-Watkins, RT, RPSGT
COO/Chief Operations Officer

Print Your Name: _____ DOB: _____ Date: _____



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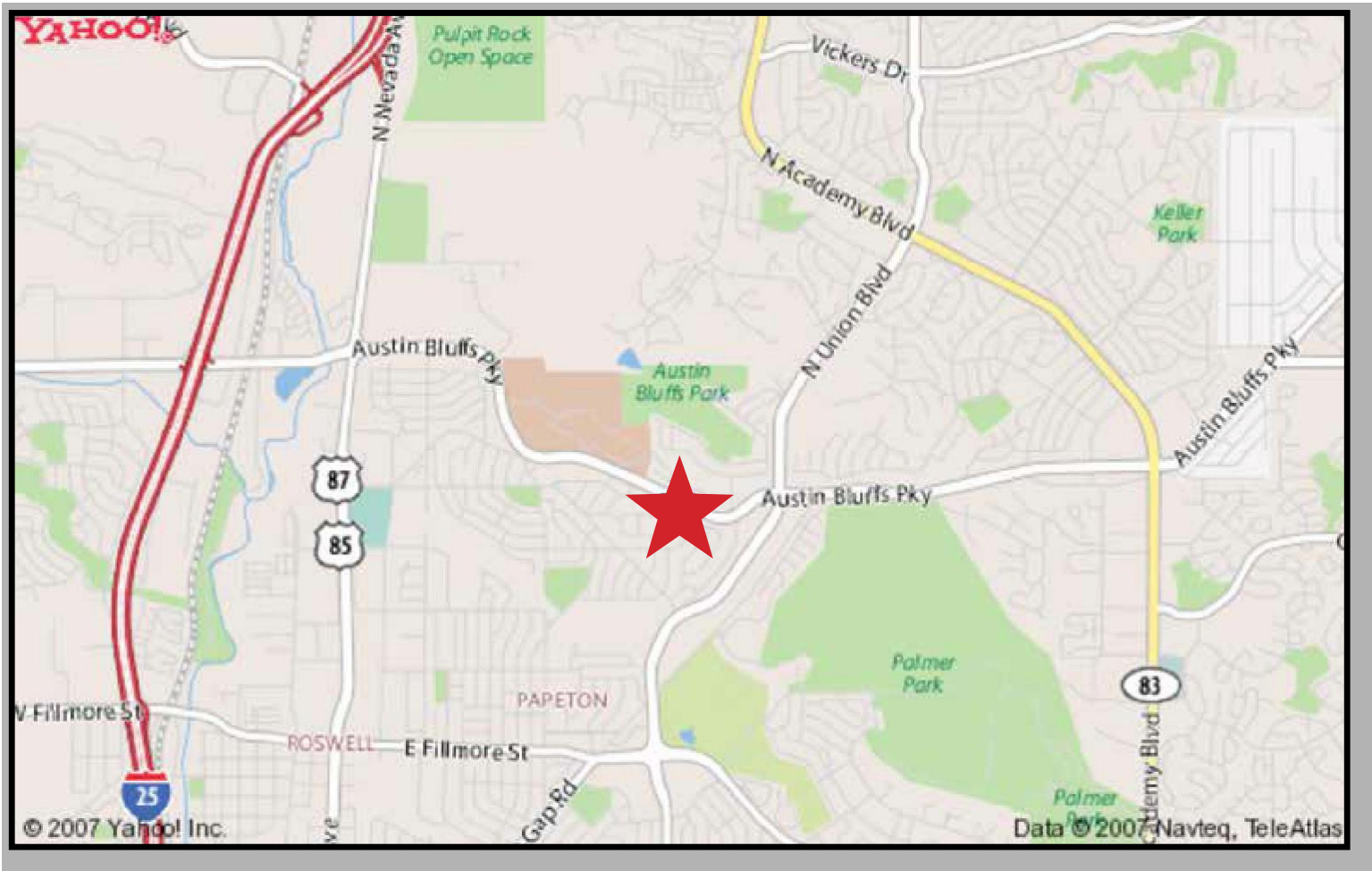
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The Colorado Springs sleep center is located at 1849 Austin Bluffs Parkway Colorado Springs CO 80918.

The phone number is (303) 956-5145 after 8pm if you are delayed or cannot find the Sleep Center.



Directions:

From Intersection of Austin Bluffs and Union – Proceed West on Austin Bluffs Parkway. Make your first left into College Office Park. The sleep center is the building straight ahead.

From I-25 – Exit on Garden of the Gods Parkway (#146) and proceed East. Garden of the Gods Parkway will become Austin Bluffs Parkway. After passing the UCCS/Meadows signal light, make your next right into the University Office Park. The sleep center is straight ahead.

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SLEEP HISTORY

Last Name: _____ First Name: _____

Date of Study: _____ race/Ethnicity: _____

Social security number: _____ Date of Birth: _____

Primary residence Address: _____

Phone: _____

Height: _____ Weight: _____ Neck Size: _____ in. Gender: Female Male

Spouse or emergency contact(s): _____ Phone: _____

referring Physician(s): _____

CHIEF COMPLAINT

Check any of the following that apply:

- Loud snoring
- Breathing or snoring stops for brief periods in my sleep Awaken
- gasping for breath
- Do not feel restored when I awaken

Become sleepy during the day (please circle any/all that apply)

- sitting talking riding eating driving standing Difficulty
- falling asleep Difficulty remaining asleep Awaken too early

My MAIN sleep problem has bothered me:

- Less than 12 months Greater than 1 year

SLEEP TREATMENT (please check answer)

I have had a nocturnal pulse oximetry test: Yes No If yes, when? _____

I have had a sleep study: Yes No If yes, when and where?

I was previously diagnosed with Sleep apnea: Yes No If yes, when and where?

I still have my tonsils and adenoids: Yes No When removed? _____

I have been told I have a deviated septum: Yes No ENT surgery is an option: Yes No

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MEDICATION

List current medications and dosages, including both prescription and over-the-counter medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Do you smoke? Yes No Did you previously smoke? Yes No

If yes, how many years of smoking? _____ How much per day? _____

Do you drink alcohol? Yes No If yes, how much? _____ drinks per day week month

How much caffeinated coffee, tea or cola do you drink daily? _____

What activity level do you expend at work? Heavy Moderate Light Sedentary

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Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep: *Number of times per week*

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble or nasal congestion interfering with sleep
				Shortness of breath disrupting sleep

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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**

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g., a theater 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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Print

Submit

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Consent for Treatment

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights to privacy with respect to your health care information.

Consent Related to Privacy Notice:

I have had a chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for Care:

I, with my signature, authorize Professional Sleep Services, Inc, and any of its employees working under the direction of the Medical Director, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health care (or the person identified) and may include (but not limited to) preventative, diagnostic, therapeutic, maintenance, assessment and review of physical/mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with the prescription. The consent includes contact and discussion with other health care professionals for the care and treatment.

Patient Signature: _____

Date: _____

Responsible Party Name (Print): _____

Responsible Party Signature: _____

Date: _____

Print Your Name: _____ DOB: _____ Date: _____



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Patient Financial Responsibility Disclosure and Acknowledgment

Your signature on the line below forms a legally binding agreement between Professional Sleep Services, Inc. and the undersigned patient (the "Patient") who is receiving medical services, or the responsible party for minor patients (those patients under 18 years of age). The Responsible Party is the individual who is financially responsible for payment of medical bills associated with the medical services provided by Professional Sleep Services, Inc., and is the individual indicated on the form below as the Responsible Party in the space provided. **All charges for services rendered are due and payable at the time of service.**

Professional Sleep Services has contracts with numerous third party insurance companies and Professional Sleep Services, Inc. will bill such third party insurance companies for services rendered to you by Professional Sleep Services, Inc. as a service to you. The Responsible Party is responsible for payment for services rendered in the event that your insurance declines to make payment for any services rendered for any reason whatsoever. The Responsible Party shall also be responsible for making any and all required co-pays and deductibles. The Responsible Party shall also be responsible for paying any additional amount owing after claim submission to the Patient's insurance and will be billed for any such deficit after Professional Sleep Services, Inc. receives an explanation of benefits (EOB) from the Patient's insurance company.

The Responsible Party shall:

- Provide, and update to maintain current, the Responsible Party's current address and phone number for both the Responsible Party and the Patient.
- Present all current insurance cards prior to each of the Patient's office visits.
- Verify at each office visit that the information, including address, phone number, and insurance information is accurate and current by signing Professional Sleep Services, Inc. data sheet.
- Pay any required co-pay at the time of each office visit.
- Pay any additional amount owing within thirty (30) days of receiving a statement from Professional Sleep Services Inc; it being understood that Professional Sleep Services Inc. will bill the Responsible Party for any amounts not paid by the insurance company as set forth on the EOB received from the Patient's insurance company.

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Returned Checks – If payment is made by check and the check is returned unpaid for insufficient funds, or unpaid for any other reason, the Responsible Party shall be financially responsible to Professional Sleep Services for the original face amount of the returned check plus a service charge equal to \$35.00 (the “Service Charge”). Professional Sleep

Services will notify Responsible Party by mail in the event that a check is returned and shall in such notice provide fifteen (15) days from the date of the notice for repayment by the Responsible Party of the face amount of the check plus the Service Charge. If payment of the face amount of the check plus the Service Charge is not received by Professional Sleep Services Inc. within the applicable 15 day time period, then Professional Sleep Services, Inc may turn the account over to a collection agency for collection of the same. The Responsible Party shall be responsible for all costs of collection in addition to the face amount of the check and Service Charge.

Non-Payment – In the event that Professional Sleep Services Inc. should initiate collection proceedings or other legal action to collect an overdue account, the Patient and Responsible Party each acknowledge and understand that Professional Sleep Services Inc. has the right to and shall disclose to its outside collections agency all relevant personal and account information necessary to collect payment for services rendered, including any applicable service charges and applicable costs of collections. The Patient and the Responsible Party each understand and acknowledge that they are responsible for all costs of collection, including without limitation attorneys’ fees and costs, and that interest shall accrue on all unpaid balances at the rate of 18% per annum until repaid in full (1.5% billing cycle).

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the Responsible Party, as applicable. Your signature below verifies that you have read the above disclosures, understand your responsibilities, and agree to the terms set forth herein.

Patient Signature: _____

Date: _____

Responsible Party Name (Print): _____

Responsible Party Signature: _____

Date: _____

Print Your Name: _____ DOB: _____ Date: _____