
**PHONE: (303) 396-5923 FAX: (303) 957-5414**

# PATIENT REGISTRATION

**Please take the time to review this information ensure all required fields, outlined by asterisks*, are filled out correctly and in entirety.**
**Please also be certain to sign all consents on the pages following the registration form.**

## Patient Demographics

**1. General Patient Information**

*First Name: _____ Middle Initial: _____ *Last Name: _____ Preferred Name: _____

*Date of Birth: _____ *Gender: ○ Male ○ Female ○ Prefer Not to Answer

Social Security Number: _____

*Street Address: _____ *City: _____ *State: _____ *Zip Code: _____

*Mobile Phone: _____ Home Phone: _____

Email Address: _____

*Do you have a smart phone or tablet & are willing to use it for a Home Sleep Test? _____

What is your approximate elevation? _____

**2. Responsible Party- Only complete if patient is a minor**

First Name: _____ Last Name: _____

Relationship to Patient: _____ Date of Birth: _____

Mobile Phone: _____ Home Phone: _____ Email Address: _____

**3. Primary Insurance- Please list "N/A" or "Self" if you do not have insurance**

*Primary Insurance Company: _____ *Member ID/Policy Number: _____

Group Number: _____ Patient's Relationship to Insured: _____

Insured Name: _____ Insured Date of Birth: _____

**4. Secondary Insurance**

Secondary Insurance Company: _____ Member ID/Policy Number: _____

Group Number: _____ Patient's Relationship to Insured: _____

Insured Name: _____ Insured Date of Birth: _____

## Health/Sleep History Questionnaire & Medical History

**6. What is the primary reason for your visit (sleep apnea/snoring, insomnia, poor sleep, excessive sleepiness/fatigue, review results, check CPAP etc.)?** _____

_____

**7. Previous Study, PAP & O2?**
Have you had a previous sleep study? _____ - If yes, when? _____

Are you currently using a PAP machine? (CPAP, APAP) _____

Do you use O2? _____

**8. What is your height? _____ What do you currently weigh in lbs? _____ What is your neck size? _____**

**9. *Epworth Sleepiness Scale: How likely are you to fall sleep in the following situations?**
0: Would Never Dose 1: Slight Chance of Dozing 2: Moderate Chance of Dozing 3: High Chance of Dozing

| **Situations:** | **0** | **1** | **2** | **3** |
|---|---|---|---|---|
| Sitting & Reading | ☐ | ☐ | ☐ | ☐ |
| Watching TV | ☐ | ☐ | ☐ | ☐ |
| Sitting, inactive in a public place (a theater or meeting) | ☐ | ☐ | ☐ | ☐ |
| As a passenger in a car for an hour without break | ☐ | ☐ | ☐ | ☐ |
| Lying down to rest in the afternoon when able | ☐ | ☐ | ☐ | ☐ |
| Sitting & talking with someone | ☐ | ☐ | ☐ | ☐ |
| Sitting quietly after lunch without alcohol | ☐ | ☐ | ☐ | ☐ |
| In a car, while stopped for a few minutes in traffic | ☐ | ☐ | ☐ | ☐ |

**10. Please check the box next to any of the following medical conditions you have. This could be currently or diagnosed in the past. If you have a diagnosis/disorder that is not listed please use the blank area to let us know this diagnosis.**

☐High Blood Pressure ☐ High Cholesterol or lipids (taking a statin) ☐ Heart Disease (heart attack/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 ☐ GERD/Acid Reflux/Heartburn ☐ Anxiety

☐ Depression ☐ Bipolar Disorder ☐ ADHD ☐ Chronic pain ☐ Migraines

☐ Hypothyroidism ☐ Autism/Cognitive Impairment/Dementia

Not Listed: _____

**11. Please list all medications you're currently taking, including over-the-counter medications.**

_____

_____

**12. Do you have allergies to any medications?**

○ No ○ Yes - if yes, please list the medication(s) _____

**13. Sleep Related Breathing Disorders, Restless Legs, Parasomnias, Insomnia & Hypersomnia:**

| **Sleep Related Breathing Disorders Questions:** | **Yes** | **No** |
|---|---|---|
| Does anyone sleep next to you or in the same room as you currently? | ☐ | ☐ |
| Have you ever been told you snore? | ☐ | ☐ |
| Do you ever stop breathing or have shallow/irregular breathing while sleeping? | ☐ | ☐ |
| Do you ever wake up snoring, coughing, choking, gasping for air, or feel short of breath? | ☐ | ☐ |
| Do you wake up with a headache? | ☐ | ☐ |
| **Restless Leg Questions:** | **Yes** | **No** |
| Do you have an urge to move your legs, or an unpleasant sensation in the legs? | ☐ | ☐ |
| Has anyone ever said you move a lot in your sleep, but the movement doesn't bother or wake you? | ☐ | ☐ |
| **Parasomnia Questions:** | **Yes** | **No** |
| Do you have persistent nightmares that wake you from sleep? | ☐ | ☐ |
| Ever been told you sleep walk? | ☐ | ☐ |
| Ever been told you sleep talk? | ☐ | ☐ |
| Do you ever physically act out your dreams, such as running or punching in your sleep? | ☐ | ☐ |
| Do you ever see things that don't exist (such as shadows or figures) as you wake up (hallucinations)? | ☐ | ☐ |
| Do you ever wake from sleep feeling paralyzed or unable to move? | ☐ | ☐ |
| **Insomnia Questions:** | **Yes** | **No** |
| Do you have issues falling or staying asleep, or waking earlier than intended? | ☐ | ☐ |
| **Hypersomnia Questions:** | **Yes** | **No** |
| Do you wake feeling rested/restored by sleep? | ☐ | ☐ |
| Do you often find yourself feeling very tired or sleepy during the day? | ☐ | ☐ |

Please proceed to next page for consents requiring signature.

# Consent for Treatment

**Request for Provision of Service:** I understand that by signing this consent I hereby give permission to MSD and its agents to perform testing and treatment.

**Records and Release of Information:** Transmitted Data may become part of my medical record. Mountain Sleep Diagnostics may use or disclose my health information consistent with my signed release of information, or, without my consent for treatment, payment, or healthcare operations, or when required by law. All releases of information are subject to the same laws and regulations.

**Video and Audio Taping:** I hereby give my consent for videotaping, audio taping and/or photography for professional use in diagnosing and recommending treatment. I understand that my name will be kept confidential at all times, regardless of the use of these recordings.

**Assignment of Benefits & Financial Responsibility:** 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 Diagnostics any and all information pertaining to my insurance benefits and 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 agree to pay all bills promptly and in accordance with MSD's rates and terms. At the time of the visit, I will pay any co-payment, co-insurance and/or deductible amounts that are due. I will also pay the balance due after payment by any insurer or third-party payer. I understand MSD may charge for late cancellation (within 48 hours) and/or missed appointments. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses.

**MSD Privacy Practices:** Privacy practices for Mountain Sleep Diagnostics can be located at www.mountainsleepdiagnostics.com under Legal Notices. We encourage you to read in totality.

**Contact Consent:** 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. 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.

**Consent for Voicemail:** I give my consent for MSD, associated providers and staff to leave specific information regarding my study, treatment or other services provided by MSD on my personal voicemail using the number MSD has on file.

☐**Yes**
☐**No**

**Disclosure of Information:** I give Mountain Sleep Diagnostics and their staff permission to share information regarding my medical care with the following individuals:

_____ _____
_____

**Health Information Exchange:** By consenting to treatment provided by MSD you are also opted in to the Health Information Exchange. 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. If you would like to Opt Out of the Health Information Exchange, please reach out to us at (303) 392-5923 to obtain an Opt Out form for signature.

**Patient Name (Printed):** _____

**Patient's Legal Representative Name (Printed):** _____

**Relationship to Patient:** _____

*Use if patient is a minor or you serve as their medical power of attorney*

**Signature:** _____ **Date:** _____


# Consent for Telehealth

Mountain Sleep Diagnostics offers appointments and limited services via telehealth. Telehealth involves remotely treating patients through telecommunications systems, including information, electronic, and communication technologies, while patient and provider are located at separate sites. Telehealth involves using a virtual platform to treat patients remotely using audio and video transmission, including the electronic transmission of my private health information ("PHI")(collectively, "Transmitted Data"). Though MSD takes steps to ensure Transmitted Data is sent via secure electronic means, I understand that there is a possibility that Transmitted Data could be intercepted and become available to a third-party. I understand that all confidentiality protections required by law or regulation will apply to my care.
I understand that due to the nature of medical practice, not all medical services may be available via telehealth, and it is within the sole discretion of my provider to determine whether telehealth is appropriate for my care and treatment. I understand that I have the right to refuse or stop participation in telehealth services at any time.

**Emergency Cases:** In the event you are conducting your telehealth visit and experience a medical emergency, please immediately call 911 and as much as possible, stay connected with your telehealth provider until help arrives.

**Fees:** You/your insurance will be billed for your telehealth visit and you will be responsible for any fees that are assigned patient responsibility. Please note that we will not continue a telehealth visit if you are operating a car or are in a situation that we determine could be dangerous. If we have to disconnect for these reasons, this may result in a fee for the provider's time spent preparing for the visit and attempting to conduct said visit.

By signing this form, I hereby declare that I agree and understand the information above.

**Signature:** _____ **Date:** _____

# Authorization to Release Patient Health Information | Personal Medical Records Release

This authorization is necessary for us to comply with state and federal laws pertaining to the request and or release of medical records regarding the patient identified below. Please provide all of the requested information. Failure to provide all requested information may prevent Mountain Sleep Diagnostics from acting on this authorization.

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

Person/Entity Authorized to Release:

| | |
|---|---|
| Name: | Mountain Sleep Diagnostics |
| Phone/Fax: | (303) 396-5923 \| (303) 957-5414 |

Request Medical Records Sent To: Please list yourself or your minor as you are authorizing us to share your records with you.
***Please note: If you require us to send your records elsewhere in the future, you will request a new record release form to complete*

| | |
|---|---|
| Name: | |
| Address: | |
| Phone/Fax: | |

Records Requested:

☐All Medical Records

☐Records for a certain date range: to

☐Billing Records Only

☐Other (please specify):

Sensitive Data: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐I Authorize Release

☐I Do Not Authorize Release

☐This is not applicable to me

*I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.*

**Date:** _____ **Signature:** _____

*Please note, this request will expire 365 days from signature date. A copy of your Drivers' License is required to execute the requests of this document.*