Mountain Sleep Diagnostics

Annual Patient Registration Update

Demographics

Patient Information

Patient Last Name	First Name	Middle Name	
Address	City	State	Zip
Home Phone	Work Phone	Mobile Phone	

Sex ◯ Male ◯ Female	Date of Birth	Age	Social Security #	Driver's License #
Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed			Spouse's Name	E-Mail
Employer Name			Employee Address	
Primary Care Physician	Phone Number		Referring Physician	Phone Number

Race (Optional)		Ethnicity (Optional)	Primary Language
◯ White	◯ African American	◯ Hispanic/Latino	
◯ Asian	◯ American Indian	◯ Non-Hispanic/Latino	
◯ Alaskan	◯ Hawaiian	◯ Declined	

Complete this section only if the patient is a minor.

Responsible Party

Responsible Party - Last Name	First Name	Middle Name	
Address	City	State	Zip
Home Phone	Work Phone	Mobile Phone	

Sex ◯ Male ◯ Female	Date of Birth	Age	Social Security #	Driver's License #

Please bring your insurance card to every appointment to keep your account current

Insurance

Primary Insurance Company	Effective Date	**Secondary** Insurance Company	Effective Date
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder - SS #	Relationship to Patient	Policy Holder - SS #	Relationship to Patient

Financial Responsibility

I hereby authorize payment of medical benefits directly to Mountain Sleep Diagnostics and/or affliates. 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 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.

X _____

Signature of Patient, Parent or Legal Guardian Date

Mountain Sleep Diagnostics

New Patient Registration Form

Demographics

Privacy Practices

Acknowledgement of Receipt of the MSD Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices ("The Notice") for the practice of Mountain Sleep Diagnostics.

Signature of Patient (or Patient Representative**) Date

**** If Patient Representative, legal documentation must be included to show authority to sign or receive information**

For Practice Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ◯ Patient refused to sign
- ◯ Other (Please Specify) _____
- ◯ Communication barriers prohibited obtaining acknowledgement
- ◯ An emergency situation prevented us from obtaining acknowledgement

Approved HIPPA Contacts

Whom may we disclose healthcare information to, on your behalf?

I Do consent MSD to leave detailed messages as follows: ◯ **DO NOT SPEAK TO ANYONE**

I, _____, give Mountain Sleep Diagnostics and their staff permission to leave messages regarding my medical care with the following (**This will remain in effect until you change it in writing)**

- ◯ Home Phone _____ Initials _____
- ◯ Cell Phone _____ Initials _____
- ◯ My Spouse _____ Initials _____
- ◯ Family (Other) _____ Initials _____

Emergency

Emergency Contact Information

Emergency Contact Name _____ Relationship to Patient _____

Emergency Contact Phone Number _____

Other Financial Information

If you are insured, please provide our office with your current insurance ID card(s) every time you come in for a visit. **If you do not have insurance, 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 paper work 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**. If we are preferred providers for your insurance (as outlined by your insurance), we will write off the appropriate amount before issuing a bill to you

$20.00 - Non-Payment of Co-Pay	**Charged in addition to co-pay if you do not pay at 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.**

Contact Consent

You agree, by providing us with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns. This express authorization also applies to any landline or cell 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 use of an automatic dialing devices, as applicable. Providing your phone numbers(s) is not a condition of receiving our services. I have read this disclosure and agree that we may be contacted as described above.

_____

Signature of Patient, Parent or Legal Guardian Date

Mountain
Sleep Diagnostics

Telehealth Patient Consent

Mountain Sleep Diagnostics allows remote communication in providing health care services to patients otherwise known as Telehealth. This includes health care services that can be made in real-time two- way audio and video communication via internet in order to evaluate, diagnose, and treat medical conditions.

Colorado law requires health care service providers to get the consent of patients prior to engagement through telehealth. With this form, we intend to get your consent before you can use the service by helping you being informed of the benefits and limitations of this method of treatment.

Telehealth a term where involves audio and video communication, as well as the exchange of digital files or images, including medical records, x-rays, etc. This mode of communication and exchange is made through a secure channel that is private between the doctor and the patient.

With Telehealth, the doctor or health care service provider is on a different location than the patient. The patient may be at home, or in a facility where the service provider other than the physician may be able to assist in the treatment. In any case, the patient shall be informed whenever it is necessary for additional personnel is needed to bepresent.

Your Right to Telehealth
Given that this is voluntary, you may withhold or withdraw your consent from participating in telehealth. Your withdrawal or your withholding of consent shall not be taken against you and you are afforded other means of health care services other than telehealth. You may again apply for a request for treatment through telehealth at any time.

Your Right to Privacy
Laws governing confidentiality to health information, including, but not limited to Health Insurance Portability and Accountability Act (HIPAA) applies in telehealth. Access to the transmission of data will be limited to the necessary people, organization, and staff of the health care service provider and shall not be transmitted to anyone outside the network unless otherwise with your prior written consent. Health insurance services have access to your medical information.

Your Right to Access to Your Information
You have the right to get a copy of your information, for a reasonable fee. You may also follow-up with your health care provider in case you have additional questions or concerns relating to your condition for which you have consulted/treated through telehealth.

Emergency Cases
In case you are in your home, you must immediately call 9-1-1 and as much as possible, stay connected with your telehealth provider until help arrives. If you are on-site such as a telehealth facility, medical personnel shall attend to you in addressing your case.

Fees
You will be billed for your telehealth visit and are personally responsible for the fees which you may incur from your visit. You shall process your reimbursements for telehealth with Medicaid if you have any, including telehealth for remote patient monitoring.

Prescriptions
The state of Colorado prevents physicians from prescribing patients dangerous and controlled substances or drugs.

By signing this form, I hereby declare that I agree and understand the information above and I have had the opportunity to ask my questions and which have been answered accordingly and to my satisfaction.

Signature of Patient, Parent of Legal Guardian **Date**

Mountain
Sleep Diagnostics

Epworth Sleepiness Scale

Date ____/____/____

Patient Name _____ DOB ____/____/____

Age (YR)_____ Male Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't 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

Situation Chance of dozing

Sitting and Reading _____

Watching TV _____

Sitting, inactive in a public place (e.g. 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 to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in the traffic _____

Total _____

SCORE	
0 – 10	Normal Range
10 – 12	Borderline
12 – 24	Abnormal

Mountain
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Modified Berlin Questionnaire

Date ____/____/____

Patient Name _____ DOB ____/____/____

Height (inches)_____Weight (lbs)_____Age_____ Male Female

Please choose the correct response to each question.

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

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

Category 3

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

Scoring Berlin Questionnaire

The questionnaire consists of 3 categories related to the risk of having sleep apnea. Patients can be classified into High Risk or Low Risk based on their responses to the individual items and their overall scores in the symptom categories.

Categories and Scoring:
Category 1: items 1, 2, 3, 4, and 5; Item 1: if '**Yes**', assign **1 point**
Item 2: if '**c**' or '**d**' is the response, assign **1 point** Item 3: if '**a**' or '**b**' is the response, assign **1 point** Item 4: if '**a**' is the response, assign **1 point**
Item 5: if '**a**' or '**b**' is the response, assign **2 points**
Add points. *Category 1 is positive if the total score is 2 or more points.*

Category 2: items 6, 7, 8 (item 9 should be noted separately). Item 6: if '**a**' or '**b**' is the response, assign **1 point**
Item 7: if '**a**' or '**b**' is the response, assign **1 point**
Item 8: if '**a**' is the response, assign **1 point**
Add points. *Category 2 is positive if the total score is 2 or more points.*

Category 3 is positive if the answer to item 10 is '**Yes**' or if the BMI of the patient is greater than 30kg/m2.
(BMI is defined as weight (kg) divided by height (m) squared, i.e.., kg/m2). **High Risk:** if there are 2 or more categories where the score is positive. **Low Risk:** if there is only 1 or no categories where the score is positive.

Additional Question: item 9 should be noted separately.