



**PLEASE BRING YOUR INSURANCE CARD AND A FORM OF IDENTIFICATION**

Your physician has requested that you have a sleep study. In follow up to the phone call, you have been scheduled for this sleep study. For more information you may visit our website, [www.sleepcaresolutions.com](http://www.sleepcaresolutions.com)

Address: **Sleep Care Solutions of Miami, LLC**  
**5995 SW 71st Street**  
**3<sup>rd</sup> Floor**  
**Miami, Florida 33143**

**(305) 666-8800 Office**  
**(305) 666-8801 Fax**  
**(786) 347-7222 After 8 pm**

It is VERY important that you follow these instructions carefully.  
Should you have any questions, please call our office.

**IF YOUR APPOINTMENT IS ON A SATURDAY OR SUNDAY, PLEASE CALL OUR OFFICE THE FRIDAY BEFORE TO VERBALLY CONFIRM.**  
**PLEASE ARRIVE NO EARLIER THAN 8:00 P.M. OR LATER THAN 8:30 P.M.**

**You may park in the reserved parking spaces in front of the building.**

**YOUR SLEEP STUDY WILL BE COMPLETED BY 6 A.M. THE FOLLOWING MORNING.**

**PLEASE REMEMBER NOT TO CONSUME ANY CAFFEINATED PRODUCTS THE DAY OF YOUR STUDY, NOR TAKE A NAP.**

DIRECTIONS TO  
SLEEP CARE SOLUTIONS OF MIAMI

From S. Dixie Highway points NORTH of Sunset Drive:

1. Take S. Dixie Highway SOUTH
2. Cross the light at Red Road/SW 57<sup>th</sup> Avenue
3. Turn right (west) at the next light onto SW 70<sup>th</sup> Street and drive three blocks
4. Turn left at light (SW 59<sup>th</sup> Place) and turn right onto next street (SW 71<sup>st</sup> Street), pass the hotel on the right and right into the next driveway. Park in any of the reserved parking facing the building. Enter the front door and take the elevator to the third floor. Please call the sleep lab at 786-347-7222 if you get lost.

From S. Dixie Highway points SOUTH of Sunset Drive:

1. Take S. Dixie Highway NORTH
2. Cross the light at Sunset Drive/SW 72<sup>nd</sup> Street
3. Turn left (west) at the next light onto SW 70<sup>th</sup> Street and drive three blocks.
4. Turn left at light (SW 59<sup>th</sup> Place) and turn right onto next street (SW 71<sup>st</sup> Street), pass the hotel on the right and right into the next driveway. Park in any of the reserved parking facing the building. Enter the front door and take the elevator to the third floor. Please call the sleep lab at 786-347-7222 if you get lost

From Palmetto Expressway, Sunset Drive (SW 72<sup>nd</sup> Street) exit:

1. Take Sunset Drive East (towards S. Dixie Highway/US 1)
2. Turn left (north) onto SW 62<sup>nd</sup> Avenue
3. Turn right (east) onto SW 70<sup>th</sup> Street (Larkin Community Hospital is on the corner)
4. Pass first block and turn right onto the second block (SW 61<sup>st</sup> Avenue). Turn left onto SW 71<sup>st</sup> Street, pass the empty field, and turn left into the first driveway. Park in any of the reserved parking facing the building. Enter the front door and take the elevator to the third floor. Please call the sleep lab at 786-347-7222 if you get lost

## INSTRUCTIONS FOR THE TEST

Please read and understand this simple list of instructions. It is very important that you follow these to guarantee a successful sleep study:

1. Bring something loose and comfortable to wear while sleeping.
2. Feel free to bring a book or a favorite pillow. Please note each room has a cable television should you wish to watch TV prior to going to sleep.
3. Wash and dry your hair on the day of your sleep test prior to coming to the lab. Do not to use any hair products, such as gels, hairsprays or heavy conditioners, because it may prevent the electrodes from adhering to your scalp.
4. Please do not wear make-up. Some electrodes are on the face, so this area must be clean in order to get a good connection.
5. Remove nail polish and/or artificial nails from at least two fingers. The oximeter that is placed on your finger to monitor blood oxygen levels reads this information through the nail, so any polish or acrylic will not provide an accurate reading.
6. Bring your own toiletries such as a toothbrush, toothpaste, hairbrush or comb. Showers are available for your use.
7. Bring clothes for the following day.
8. Patients are encouraged to take current medication prior to arrival. If you are prescribed a sleeping medication by your doctor, you may bring it with you and take it upon arrival.
9. Try to get a normal night's sleep before the test, unless instructed otherwise by your doctor. Continue to take your regular medications and limit caffeine intake the day of your test. Please also avoid any alcohol consumption the day of your study.
10. If you are having a CPAP study, it is NOT necessary to bring your own machine if you already have one. You may, however, bring your CPAP mask or nasal pillows.

**Please call at least 24 hours in advance if you need to reschedule your appointment: (305) 666-8800**

## Patient Registration Form

### Patient Information

Date \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

\_\_\_\_ Minor \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Widowed \_\_\_\_ Seperated \_\_\_\_ Divorced

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

If Student, Name of School: \_\_\_\_\_

Spouse / Parent's Name: \_\_\_\_\_

Spouse / Parent's Employer: \_\_\_\_\_

Spouse / Parent's Employer Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Responsible Party

Relation to Patient: \_\_\_\_ Self \_\_\_\_ Spouse \_\_\_\_ Parent \_\_\_\_ Other \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Patient Registration Page 2**

**Insurance Information**

Name of Insured: \_\_\_\_\_

Relation to Patient: \_\_\_ Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Insurance Address: \_\_\_\_\_

**\*\*\*\*\*DO YOU HAVE ADDITIONAL INSURANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO\*\*\*\*\***

IF YES COMPLETE BELOW

Name of Insured: \_\_\_\_\_

Relation to Patient: \_\_\_ Self \_\_\_ Spouse \_\_\_ Parent \_\_\_ Other \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Phone: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Insurance Address: \_\_\_\_\_

# SLEEP HISTORY

## 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
  - riding
  - driving
- Difficulty falling asleep
- Difficulty remaining asleep
- Awaken too early

- My MAIN sleep problem has bothered me:
- 1 to 2 years
  - longer than 2 years
  - several months to 12 months
  - within the last 3 months
  - within the last month

## WEIGHT

- What is your height? \_\_\_\_\_
- What is your weight? \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_
- What is your collar size? \_\_\_\_\_ 1 year ago \_\_\_\_\_ 5 years ago \_\_\_\_\_

## MEDICATION

Do you take anything to help you sleep? Y/N What? \_\_\_\_\_ How often? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Are you on supplemental oxygen? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much? \_\_\_\_\_ (Liters/min)

## SOCIAL HISTORY

- Do you smoke? \_\_\_\_\_ Did you previously smoke? \_\_\_\_\_
- How many years of smoking? \_\_\_\_\_ How much per day? \_\_\_\_\_
- Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_ drinks per (day/week/month) (please circle)
- How much caffeinated coffee, tea or cola do you drink daily? \_\_\_\_\_
- What do you usually do at work? \_\_\_\_\_

## ENVIRONMENT

- Is your bedroom (loud/quiet) and (light/dark)? (please circle)
- Is your mattress (soft/hard/just right)? (please circle)
- Do you go to sleep with the television on? Yes \_\_\_\_\_ No \_\_\_\_\_
- Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes \_\_\_\_\_ No \_\_\_\_\_

**PRIOR AND CURRENT SLEEP TREATMENT:**

I was previously diagnosed with:

\_\_\_ Sleep apnea      When? \_\_\_\_\_      Where? \_\_\_\_\_

My prior treatment included:

\_\_\_ CPAP or BiPAP or Bilevel      \_\_\_ Uvulopalatopharyngoplasty  
Indicate treatment level (if known) \_\_\_\_\_      \_\_\_ Laser or other procedure on uvula  
\_\_\_ Oral appliance      \_\_\_ Mandibular surgery  
\_\_\_ Sinus, deviated septum or turbinate reduction      \_\_\_ Tonsils and/or adenoidectomy

\_\_\_ Restless legs syndrome  
When? \_\_\_\_\_      Where? \_\_\_\_\_      Treatment: \_\_\_\_\_

\_\_\_ Periodic limb movements  
When? \_\_\_\_\_      Where? \_\_\_\_\_      Treatment: \_\_\_\_\_

\_\_\_ Narcolepsy  
When? \_\_\_\_\_      Where? \_\_\_\_\_      Treatment: \_\_\_\_\_

\_\_\_ Insomnia  
When? \_\_\_\_\_      Where? \_\_\_\_\_      Treatment: \_\_\_\_\_

**FAMILY HISTORY**

Do you have any family members (Grandparents, parents, brothers, sisters) with any history of sleep problems, including Apnea, Snoring, Narcolepsy, Insomnia, or other? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Applicable \_\_\_\_\_

If yes, briefly Describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY**

Please check if you have had any of the following:

- ( ) Heart disease    List type: \_\_\_\_\_      ( ) Diabetes      ( ) Depression
- ( ) High blood pressure      ( ) Asthma/Emphysema      ( ) Reflux      ( ) Thyroid condition
- ( ) Fibromyalgia      ( ) Anxiety      ( ) Seizures      ( ) Parkinson's disease
- ( ) Stroke      ( ) Head Injury or brain surgery

( ) Pain which disrupts sleep. The typical location(s) for this pain is/are:  
\_\_\_ Headaches      \_\_\_ Neck      \_\_\_ Back      \_\_\_ Chest      \_\_\_ Limb (arm(s) or leg(s))  
\_\_\_ Abdominal      \_\_\_ Pelvic      \_\_\_ Joint (arthritis)

( ) Other medical problems which may affect sleep (please list): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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

<i>Situation</i>	<i>Chance of Dozing</i>
Sitting and reading .....	<input type="text"/>
Watching TV .....	<input type="text"/>
Sitting, inactive, in a public place (e.g., a theater or a meeting) .....	<input type="text"/>
As a passenger in a car for an hour without a break .....	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit .....	<input type="text"/>
Sitting and talking with someone .....	<input type="text"/>
Sitting quietly after a lunch without alcohol .....	<input type="text"/>
In a car, while stopped for a few minutes in traffic .....	<input type="text"/>
Total	<input type="text"/>

# DISCLOSURES

## NON-SMOKING POLICY

Please note that for the health and safety of our patients and employees, we are a non-smoking facility. Patients will not be allowed to smoke inside the facility.

\_\_\_\_\_  
**Patient's Initials**

## RELEASE OF PERSONAL BELONGINGS

Sleep Care Solutions will not be held responsible for your personal belongings. We strongly encourage you to leave all personal items, including jewelry, cameras, extra money (please remember your copayment), etc. at home. I understand that this facility will not be held responsible for any missing articles.

\_\_\_\_\_  
**Patient's Initials**

## ADVANCE DIRECTIVES

I understand that advance directives are NOT honored at Sleep Care Solutions; and in the event of a life-threatening situation, emergency medical procedures will be instituted in every instance and patients will be transferred to a higher level of care where the decision to continue or to terminate emergency measures can be made.

\_\_\_\_\_  
**Patient's Initials**

## SLEEP STUDY PROCEDURE CONSENT

As a routine part of your sleep study, data sensors will be applied to the body, at various locations including the face, scalp, legs, chest and abdomen. A Positive Airway Pressure interface (mask or nasal pillow inserts) may be applied at the initiation or during the study as part of the therapeutic process. The undersigned acknowledges permission to apply these devices as part of the diagnosis and initiation of treatment.

\_\_\_\_\_  
**Patient's Initials**

## VIDEO / PHOTOGRAPHIC CONSENT

As a routine part of your sleep study, a video record will be made of you during your sleep test. These records will be kept as part of your medical record at our facility and will be subject to the Privacy Policy of Sleep Care Solutions.

\_\_\_\_\_  
**Patient's Initials**

## INFORMATION PRIVACY

Sleep Care Solutions, LLC will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities and have copies available for distribution. The undersigned acknowledges receipt of this information.

\_\_\_\_\_  
**Patient's Initials**

## **FINANCIAL AGREEMENT**

The undersigned patient or responsible party is responsible for the fees for service. If you have insurance that covers this service, Sleep Care Solutions, LLC will bill the insurance carrier(s) as a courtesy to you. After 60 days from the Date of Service, the balance is due and payable by the undersigned, unless other financial arrangements were previously made. PLEASE NOTE, you will have two separate charges for this test. One charge will come from Sleep Care Solutions and one charge will come from the interpreting physician. In the event of default of the payment of a claim by the Customer/Patient for services rendered under this Agreement, said Customer/Patient shall pay all costs of collection, including, but not limited to, reasonable attorney's fees, court costs, and any costs associated with the execution of any Judgment obtained against the Customer/Patient for breach of this agreement

**Disclaimer:**

The benefits quoted by your insurance company are not a guarantee of payment. The contract with the insurance company is between you and your insurance company. If for some reason the insurance company does not pay the claim, you are responsible for the amount determined by your insurance company.

\_\_\_\_\_  
**Patient's Initials**

## **AUTHORIZATION TO RELEASE INFORMATION**

In order to process a claim for benefits, I authorize Sleep Care Solutions, LLC, or its representative, to release any information regarding my medical history, symptoms, treatment, study results, and diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

## **AUTHORIZATION TO PAY BENEFITS**

I hereby authorize payment to Sleep Care Solutions, LLC of benefits paid by my insurance company. Any amount exceeding my indebtedness will be refunded. I understand that I am financially responsible for the fees for service including all non-covered services, co-payments, and deductibles. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

## **Patient Complaint**

Any patient has the right to file a complaint and may do so without coercion, discrimination, reprisal, unreasonable interruption of services. A Patient Complaint Form can be obtained from any Sleep Care Solutions LLC staff member upon request.

## **Notice of Privacy Practices**

It is the policy of Sleep Care Solutions, LLC, to be fully compliant with federal HIPPA Privacy Regulations. The Privacy Regulations establish national standards regarding disclosure of protected health information. This notice describes how your medical information may be disclosed and how you can gain access to this information. If you have any question about this notice, please contact Sleep Care Solutions Privacy Officer, at 1-800-830-4321.

### **Your Medical Record**

Sleep Care Solutions maintains a medical record for each patient that comes in contact with our program. This includes information about your office visits, hospitalization, laboratory and other test results, along with other relevant information that we receive from other healthcare providers. Your medical record is used to assist us in providing you with the best possible care and medical treatment. Additionally, these records are used for:

1. Documenting and communicating to other health care practitioners precisely what care you have received.
2. Assisting you and your health insurance company to understand all fees charged for your care.
3. Meeting a variety of legal obligations, some of which require us to communicate with third parties.
4. Assisting in training and other operational functions that help us guarantee we provide the highest standard of care possible.
- 5.

### **You Have Important Controls Over Your Medical Record**

It is our desire that you fully understand exactly what rights and controls you have over your medical records. A knowledgeable patient can become more involved in their healthcare decisions and exercise greater control over the accuracy of the content and third-party access to their health information. Pursuant to the HIPPA Privacy Regulations, patients have a right to:

1. Receive a copy of the Notice of Privacy Practices
2. Request restrictions on disclosures of protected health information
3. Request alternative means of communicating Private Health Information.
4. Inspect and obtain copies of Private Health Information
5. Request amendments to Private Health Information
6. Receive an accounting of disclosure of Private Health Information.

## **Our Responsibilities and Practices**

Sleep Care Solutions is required by law and our own high professional standards to maintain the privacy and security of your Protected Health Information. This Notice is intended to give you an understanding of our legal responsibilities and privacy practices.

1. Maintenance of policies and practices that protect the privacy of your health information.
2. Securing your electronic records from premature destruction and unauthorized disclosure.
3. Notifying you when we are unable to agree to a requested restriction.
4. Accommodating reasonable requests to restrict access to your information.
5. Abiding by the privacy practices described in this notice and any updates to this notice.

## **Examples of the Privacy Policy**

**Emergencies:** In the event of an emergency which threatens the health or well being of our patient, we use and disclose health information in a manner that is most likely to protect and restore the health of an individual. While privacy is always important, it takes a lower priority when the health and well being of a patient is threatened in an emergency.

**Referrals:** When we receive a referral from another physician, we routinely keep that physician informed about their patient's health status. We do not require a patient to sign an authorization for release of information to the physician that referred them to our program.

**Treatment:** We use and disclose a patient's health information for our own treatment purposes as we deem appropriate under professional standards for quality and timeliness of care. This includes the ordering of tests, making referrals, receiving consultation or using third parties in other ways to further patient care and treatment while under our care.

**Payment physician. :** We use and disclose patient information in order to obtain payment for services. On occasion, we are required to provide information to other health care providers so that they can receive payment from services provided. As an example, we coordinate patient information with the hospital to facilitate payment for inpatient services delivered while one of our doctors has acted as your attending

**Business Operations:** To ensure the on-going quality of care and efficient health care delivery to our patients, we employ a variety of internal processes, programs, reviews, and controls. These procedures often require that our personnel have access to a patient's health information.

**Communications:** As it is critical that we communicate with our patients in an effective and timely fashion, it is sometimes required that we use telephone messages, voice mail, answering machines, email, and other written communications. This sometimes requires communications through a spouse, family member, friend, or translator. We use our best professional judgment about acceptable methods of communicating information pertaining to appointments, treatment alternatives, test results, and other pertinent healthcare information. It is essential that patients provide us with information pertaining to with whom we cannot communicate health care information.

**Business Associates:** On a limited basis, we use outside parties (Business Associates) to assist with treatment, payment, and other healthcare operational needs. We require that all Business Associates comply with accepted privacy standards and protect the privacy of our patients to the same high standard of confidentiality that we have in dealing with patient health care information.

**Legal:** On occasion, we are required by law to release some or all of a patient's health information.

**Minimum Necessary:** Even though we can lawfully use and disclose patient information under the aforementioned circumstances, we always try to limit the use of disclosure to the minimum necessary. However, where matters of care or treatment are concerned, our priority is to disclose all information this is relevant to the patient's health.

**Changes in our Privacy Practices**

We reserve the right to change our privacy practices in the future and to make those changes applicable to patient health information, including that in effect before the effective date of the changes. Changes to our privacy practices will be posted in a public area of our office. We will also strive to notify patients with revisions of this Privacy Policy Document at the next service delivery encounter with our office.

**Complaints About Our Management of Private Health Information**

In the event that you feel that any of your privacy rights have been violated or if you believe that our use or disclosure of your protected health information violates the law or does not comply with our Privacy Practices in effect at the time of the event in question. You may contact our Privacy Officer, Tim Powers, at 1-800-830-4321. We will accept and investigate your complaints promptly. Federal Law and our own professional standards prohibit retaliation of any kind for your filing a complaint. You also have the right to file a complaint directly to the Secretary of the United States Department of Health and Human Services.

This policy is in effect as of August 13, 2003.

**Acknowledgment of Receipt of Privacy Notice:**

My signature below verifies that I have received and read this Notice of Privacy for Sleep Care Solutions, LLC. I understand that I have privacy rights, including the opportunity to request restriction on the use and disclosure of my health information. I also understand that Sleep Care Solutions, LLC, encourages me to discuss with my physicians and other health care providers concerns I have about my health information. In addition, I understand that I may always contact the Privacy Officer referenced in this notice.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

**SCS Customer Complaint Hotline:**

**To report a complaint regarding the services you receive, please call toll-free:**

**To report abuse, neglect or exploitation, please call toll-free:**

**1-800-830-4321**

**1-888-419-3456**

**1-800-962-2873**