REGISTRATION FORMS

<table>
<tr><th colspan="10">PATIENT INFORMATION</th></tr>
<tr><td rowspan="2">Patient Name (Please Print)</td><td rowspan="2">Sex
□ F
□ M</td><td rowspan="2">Date of Birth</td><td colspan="5">Marital Status</td><td>Age</td><td>Social Security No.</td></tr>
<tr><td>S</td><td>M</td><td>W</td><td>D</td><td>SEP</td><td></td><td>EMAIL ADDRESS</td></tr>
<tr><td colspan="2">Street Address</td><td colspan="7">City, State, Zip Code</td><td>Home & Cell Phone Number
H: ( )
C: ( )
W: ( )</td></tr>
<tr><td colspan="2">Emergency Contact (Name)</td><td colspan="6">Relationship</td><td colspan="2">Phone No.
( )</td></tr>
<tr><td colspan="2">Occupation:</td><td colspan="6">Usual Work Hours/Days:</td><td colspan="2">Referring Physician:</td></tr>
</table>

<table>
<tr><th colspan="4">INSURANCE INFORMATION</th></tr>
<tr><td colspan="2">Primary Insurance Name</td><td colspan="2">Secondary Insurance Name</td></tr>
<tr><td colspan="2">Subscriber's Name</td><td colspan="2">Subscriber's Name</td></tr>
<tr><td>Subscriber's S.S #</td><td>Date of Birth</td><td>Subscriber's S.S #</td><td>Date of Birth</td></tr>
<tr><td colspan="2">Relationship to Patient
□ Self □ Spouse □ Child □ Other:</td><td colspan="2">Relationship to Patient
□ Self □ Spouse □ Child □ Other:</td></tr>
<tr><td>Group No.</td><td>Insured Id No.</td><td>Group No.</td><td>Insured Id No.</td></tr>
</table>

AUTHORITY FOR TREATMENT: I hereby authorize Medprime Sleep Center and/or doctors in charge of the patient to perform treatment that may be deemed necessary or advisable in the treatment of the patient. I understand that I am liable for the payment of all bills incurred.

Signature: (Parent If Patient Is A Minor) ______________________________

RELEASE OF INFORMATION: I hereby authorize Medprime Sleep Center to release any information pertaining to my health care, test results, billing and/or accounting information to the following person(s) or agencies. □ **Myself** □ **My Spouse** □ **My Insurance Company** □ **Other:** _________________

PATIENT /GUARDIAN SIGNATURE: _______________________________

INSURANCE AUTHORIZATION FOR EXTENSIVE PROCEDURES: I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Medprime Sleep Center and/or the doctor indicated on the claim.
I understand I am financially responsible for any balance not covered by my insurance carrier.

PATIENT /GUARDIAN SIGNATURE: _______________________________

MEDICARE PT'S ONLY: I request that payment of authorized Medicare benefits be made on my behalf to Medprime Sleep Center for any services furnished to me.I authorize the holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for payable related services. Regulations pertaining to Medicare assignment of benefits apply.

PATIENT /GUARDIAN SIGNATURE: _______________________________

HIPAA NOTICE OF PRIVACY PRACTICES:

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information

will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage. Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically). You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. *You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information*. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice. Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our HIPAA Compliance Officer (General Manager). Your signature below acknowledges that you have received a copy of this Notice of our Privacy Practices.

PATIENT /GUARDIAN SIGNATURE: __________________________ **DATE: _____/_____/___**

PATIENT FINANCIAL AGREEMENT: All polysomnography services consist of two components: The administration of the test (the technical component) and the provider's interpretation of the test (the professional component). Providers generally bill separately for the technical and professional components when each is performed by a different provider; some providers may perform only one component of the service. If a provider bills for the two components together, it is referred to as a "global service." There is no financial advantage to billing separately for each component as opposed to billing for a global service.

MedPrime Sleep Center: Technical Component

Potomac Ear Nose & Throat: Professional Component

Financial responsibility: I understand and agree that I am financially responsible for the payment of any co-payment, coinsurance, or deductible for health services provided to me, or my dependent by MedPrime Sleep Center & Potomac Ear Nose & Throat.

Types of Polysomnography Service	CPT code	Description
Diagnostic PSG Pediatric PSG	95810 95782	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist. Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, attended by a technologist.
Titration /Split-Night Pediatric Titration	95811 95783	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist. Polysomnography; younger than 6 years, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist
MSLT/MWT	95805	Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness
HST	95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)

PATIENT /GUARDIAN SIGNATURE: __________________________ **DATE: _____/_____/___**

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situation described below, in contrast to feeling just tired? This refers to your usual way of life in the recent times. Use the following scale to choose the most appropriate number for each situation	Never	Slightly	Moderate	High
▪ Sitting and reading	0	1	2	3
▪ Watching TV	0	1	2	3
▪ Sitting, inactive in a public place (e.g. a theatre or a meeting)	0	1	2	3
▪ As a passenger in a car for an hour without a break	0	1	2	3
▪ Lying down to rest in the afternoon when circumstances permit	0	1	2	3
▪ Sitting and talking to someone	0	1	2	3
▪ Sitting quietly after a lunch without alcohol	0	1	2	3
▪ In a car, while stopped for a few minutes in the traffic	0	1	2	3
Total (Sum of each row number) Score: 0-10 Normal range, 10-12 Borderline, **12-24 Abnormal** – Consult Your Physician to Obtain A Sleep Study for A Score Of 10 Or Greater.				

Sleep Questionnaire

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

MY MAIN SLEEP COMPLAINT(S) IS:	
☐ Trouble sleeping at night	for how many months/years? ________________
☐ Being sleepy all day	for how many months/years? ________________
☐ Snoring	Mild______ Moderate_______ Severe_________
☐ Unwanted behaviors during sleep, explain ____	

SLEEP PATTERN	Workdays weekdays	Off Days weekends
Typical bedtime:		
Typical amount of time it takes to fall asleep:		
Typical number of awakenings per night:		
Typical amount of time to fall back asleep after an awakening		
Typical time you get out of bed		

List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:

____

____

EMPLOYMENT STATUS	☐ Employed ☐ Unemployed ☐ Retired ☐ My job requires driving a vehicle ☐ I work with dangerous equipment or substances	☐ I am a shift worker on rotating shifts ☐ I am a permanent or long-term, third-shift worker ☐ I am currently a student

SLEEP HABITS	☐ I usually watch TV or read in bed prior to sleep ☐ I drink alcohol prior to bedtime ☐ I smoke prior to bedtime or when I awaken during the night ☐ I eat a snack at bedtime ☐ I eat if I wake up during the night ☐ I typically wake up from sleep to go to the bathroom ☐ I often wake up during the night ☐ I am unable to return to sleep easily if I wake up during the night ☐ I have thoughts that start racing through my mind when I try to fall asleep ☐ I wake up early in the morning, and I am still tired but unable to return to sleep ☐ I have nightmares as an adult ☐ I experience tingling sensation in my legs when I try to fall asleep ☐ I sweat a great deal during sleep ☐ I cannot sleep on my back	
HABITS	Do you smoke? ☐ Yes ☐ No *If Yes:* What? ___________Amount per Day: ________ Do you drink alcohol? ☐ Yes ☐ No *If Yes:* What? _____________Frequency:___________	
BREATHING	☐ I have been told that I stop breathing while I sleep ☐ I wake up at night choking, smothering or gasping for air ☐ I have been told that I snore ☐ I have been told that I snore only when sleeping on my back ☐ I have been awakened by my own snoring	
SOCIAL HISTORY	☐ Sleep alone ☐ Share a bed with someone	☐ Share a bedroom, but have separate beds ☐ Share a dwelling, but have separate bedrooms
DAYTIME SLEEPINESS	☐ I take daytime naps ☐ I tend to fall asleep during the day ☐ I have had "blackouts" or periods when I am unable to remember what just happened ☐ I have fallen asleep while driving ☐ I have had auto accidents as a result of falling asleep while driving ☐ I fall asleep while watching TV ☐ I fall asleep during conversations ☐ I fall asleep in sedentary situations ☐ I performed poorly in school because of sleepiness ☐ I have had injuries as the result of sleepiness ☐ I have had an inability to move while falling asleep or when waking up ☐ I have hallucinated or dreamlike images or sounds when falling asleep or waking up ☐ I drink caffeinated beverages during the day: _____cups/bottles/cans per day	
RESTLESSNESS	☐ I have uncomfortable feelings in my legs and/or arms when I lie down at night ☐ I must move my legs or walk to relieve the uncomfortable feelings in my legs ☐ I am a restless sleeper ☐ I have been told that I kick or jerk my legs and/or arms during sleep ☐ I have a hard time falling asleep because of my leg movements ☐ I have talked in my sleep as an adult ☐ I have walked in my sleep as an adult ☐ I grind my teeth in my sleep	

Medical History

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

VITAL STATISTICS

What is your: Height? ____ feet _____inches Weight? ______ pounds Neck Size: __________

What was your weight one year ago? ______ pounds Five years ago? ______ pounds

CURRENT MEDICATIONS

Medication	Dose	# Times per Day	Medication	Dose	# Times Per Day

Allergies:____

____

PAST SLEEP EVALUATION AND TREATMENT	
☐ I have had a previous sleep disorder evaluation	☐ I have had a previous overnight sleep study
☐ I have had a daytime nap study	☐ I have previously been treated for a sleep disorder
☐ I have had surgical treatment for a sleep disorder	☐ I have been prescribed a CPAP or bilevel PAP machine for home use

PAST MEDICAL HISTORY	
☐ Hypertension (high blood pressure)	☐ Diabetes
☐ Hepatitis/jaundice	☐ Depression or severe anxiety
☐ Hearing impairment	☐ Reflux
☐ Heart Disease	☐ Thyroid problems
☐ Stroke	☐ Fibromyalgia
☐ Stomach or colon problems	☐ Lung problems/COPD/asthma
☐ Alcoholism	☐ Chemical dependency or abuse
☐ TIA "Light Stroke"	☐ Blackouts
☐ Seizures	☐ Back or joint problems (arthritis)
☐ Cancer	**Female** ☐ Premenstrual syndrome ☐ Menopause **Male** ☐ Prostate problems ☐ Erectile dysfunction/impotence

List Surgeries and the year:

____

____

____

List other past medical problems and dates:

____

____

____

Check any of the following symptoms you have had in the past 12 months:

Yes	No		Yes	No	
☐	☐	Frequent headaches	☐	☐	Frequent heartburn / indigestion
☐	☐	Fainting or passing out	☐	☐	Abdominal pain
☐	☐	Sudden loss of vision or strength	☐	☐	Frequent constipation
☐	☐	Inability to speak	☐	☐	Frequent diarrhea
☐	☐	Hearing loss or ringing in ear(s)	☐	☐	Rectal bleeding / black stools
☐	☐	Hoarseness for more than 2-4 weeks	☐	☐	Difficulty urinating/ incontinence
☐	☐	Nosebleeds	☐	☐	Blood in urine
☐	☐	Cough for more than 2-4 weeks	☐	☐	Urinating more than 2 times per night
☐	☐	Coughing up blood	☐	☐	Pain in joints or bones
☐	☐	Shortness of breath or wheezing	☐	☐	Unusual bruising or bleeding
☐	☐	Swelling in feet or ankles	☐	☐	Epilepsy / seizures
☐	☐	Irregular or sudden, fast heartbeat	☐	☐	Weight loss of more than 5-10 lbs.
☐	☐	Difficulty swallowing or food "sticking"	☐	☐	Change in wart, mole or skin growth
☐	☐	Chest pain, tightness or pressure			

FAMILY HISTORY Has an immediate blood relative had any of the following

Yes	No		Relation	Yes	No		Relation
☐	☐	Cancer	______________	☐	☐	Stroke	____________
☐	☐	Diabetes	______________	☐	☐	Anxiety/Depression	____________
☐	☐	Hypertension	______________	☐	☐	Sleep Apnea	____________
☐	☐	Heart disease	______________	☐	☐	Narcolepsy	____________
☐	☐	Thyroid disease	______________	☐	☐	Other:	____________

Consent for Polysomnography

Details

A polysomnogram is an overnight sleep study. It records detailed information that shows how your body acts while you sleep. A technician will attach sensors to your body for the study. The sensors will keep track of these body functions:

Brain waves	Oxygen level
Heart rate	Breathing rate
Eye movement	Chin movement

The study also may involve other sensors. The sensors send signals to a computer. The sleep center will use this information to prepare a detailed report about your sleep. The doctor who sent you to the sleep center will receive a copy of this report. He or she will then discuss the results with you.

Risks

There is no major health risk involved with this sleep study, minor skin irritation may occur if you are sensitive to adhesives.

Agreement

My signature below indicates that I understand and agree with the following statements:

1. This sleep study may not detect the cause of my sleep problem.
2. A technician will attach sensors to my body for the study.
3. These sensors may smell bad when they are placed on me.
4. The removal of the sensors in the morning may irritate my skin and cause redness.
5. A video camera will record me as I sleep. A technician will watch me on a monitor in the control room.
6. I will be free to roll over and move in bed during the study.
7. I will need to ask for help if I must get out of bed for any reason.
8. The technician may need to enter the room to wake me if there is a problem.
9. The study may show that I stop breathing many times during the night. If this happens, a technician may enter my room to give me treatment. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers either my nose or my nose and mouth.
10. I understand why I am taking this sleep study.
11. The sleep center staff explained this sleep study to me. I understand what is going to happen during the study.

Consent for Video Recording

As part of a diagnostic sleep study, video surveillance is required. All information and data will be kept confidential. I, ______________________________________, hereby authorize the use of video surveillance for the purpose of medical diagnosis. If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

Patient /Guardian Signature: ______________________ **Date:** ___/___/__

Test Questionnaire

Patient Name: ____ **Date:** _____________

Date of Birth: _________________ Height: _____ft _____inch Weight: ________lbs

Before Exam:

1. How many hours of sleep did you get last night? ______________________________

Bedtime________________ Wake time________________

2. Did you consume any alcoholic beverages today? ________ If Yes how many? ____

3. What medications have you taken today? Prescriptions and over the counter

____

____

4.Were there any events today which had an emotional impact on you?

____

____

After Exam:

5.How do you feel you slept during the test? **( )** About the same **( )** Better **( )** Worse

6. Describe any problems you experienced during the test? (Wires or finger probe fallings off, difficulty Sleeping, etc.)

____

____

7. Can you drive your vehicle this morning? ( ) Yes ( ) No

If "No" please ask Tech to arrange transportation for you.

____

PATIENTS WITH CPAP/BiPAP, PLEASE ANSWER THE FOLLOWING QUESTIONS

How well do you feel you tolerated the mask and its pressure?

( ) Poorly ( ) Well ( ) Very well

Do you feel more refreshed?

____

____

Patient Survey

Patient Name: ______________________________**Date:** ____________________________

How long did you sleep last night?____

Was this the same, shorter or longer than usual?_______________________________________

How long did it take you to fall asleep last night?______________________________________

Was this the same, shorter or longer than usual?_______________________________________

How many times did you wake up last night?____

How long were you awake during the night?____

Did you have difficulty returning to sleep? ______If yes, why? _____________________________

Was last night's sleep better, worse or the same compared to usual? ______________________

On a scale of **1 to 5**, with **1** being very dissatisfied and **5** being very satisfied, please rate us on the following statements:

1. Quality of Room (Clean and Comfortable) **1 2 3 4 5**

2. Friendliness of Staff **1 2 3 4 5**

3. Treatment by Staff was friendly and professional **1 2 3 4 5**

4. Peaceful environment with no outside interruptions or noise **1 2 3 4 5**

5. Overall service of sleep lab **1 2 3 4 5**

6. Did you receive instructions about your visit (E-mail/call/mailed to you) prior to your sleep study from a staff member? Yes ____ No ____

7. Was your appointment scheduled within a reasonable amount of time? Yes ____ No ____

8. Did your technologist take the time to answer all questions? Yes ____ No ____

9. Was the technician pleasant, courteous, and professional? (What was your technologist's name?
____
____

10.Please list any other comments or suggestions that you must help us improve our patient care.
____
____