GLOBAL Sleep

Dear _____,

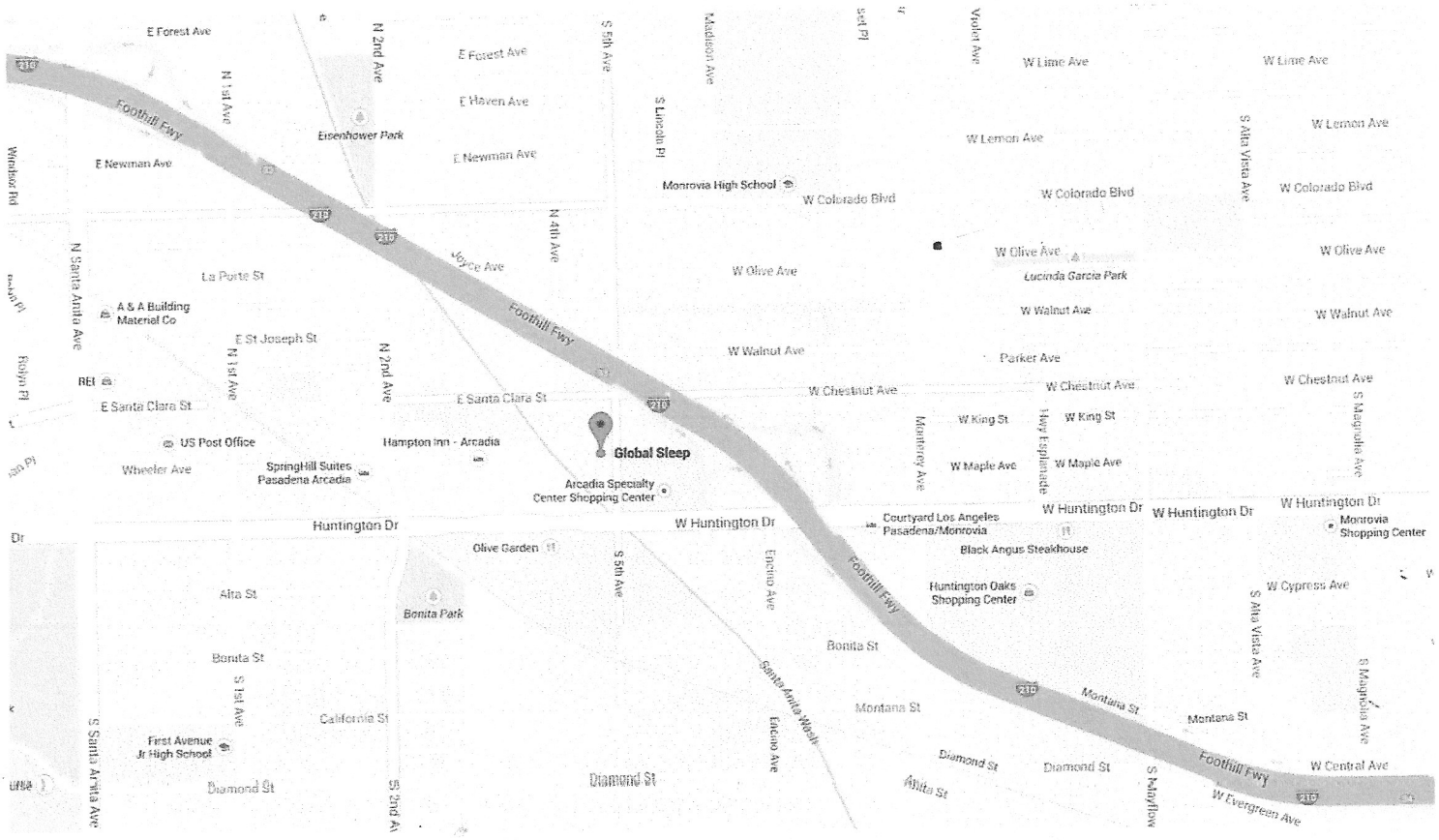
You have been scheduled for an overnight sleep study on _____/_____/_____ at _____pm. The procedure is simple and painless. Before you come to our premier sleep facility please take a few moments to read over and complete this packet of information. Thank you.

Please feel free to contact us with any questions or concerns at (626) 574-5900.

CANCELLATION: A private sleep suite has been reserved for you and a sleep specialist has been scheduled to conduct your study. If you are unable to keep your appointment it is essential that you call us at **(626) 574-5900** during business hours at least 48 hours before your appointment to avoid a **$200** cancellation charge.	**INSURANCE:** Most insurance carriers cover the procedure; however, it is important for you to understand that you are responsible for any or all of the allowable charges. In the event your insurance company does not cover the total charge or a portion of the charge for your sleep evaluation, it will be your responsibility to pay the full or remaining balance.	**RESULTS:** The results for your test will be sent to your referring physician within 5 (five) business days. Please contact your physician to schedule a follow-up appointment to discuss the findings of the sleep study and, if necessary, treatment options. If treatment is an option, Global Sleep can refer you to a company that provides medical equipment .
TRANSPORTATION: Global Sleep does not provide transportation to or from the center. If a patient needs transportation, please make arrangements prior to the scheduled appointment. If a patient needs a ride in the morning, please arrive **no later than 5:30 am** to pick up the patient.	**SPECIAL NEEDS:** The technicians that perform the sleep studies can only give limited care. If a patient has special needs it is important to have someone stay with the patient during the night of the study. If a caregiver needs to stay with the patient please tell us when scheduling your sleep study.	**TRANSLATORS:** If the patient does not speak English someone needs to come with them to their appointment to translate the instructions to the patient. This generally takes about 45 minutes, however, sometimes the translator will need to spend the night in order to help communicate with the patient during the night.

The Day of Your Study

- Please bring this **completed** packet of paperwork. Along with your insurance cards and a picture I.D.
- Please bring pajamas, favorite pillows, books, toiletries, or anything else you think will make your stay more comfortable (no pets). If you are not sure if you can bring a certain item, please give us a call prior to coming in for your appointment.
- Please arrive at your scheduled appointment time. If you arrive late the technician can cancel your appointment and you will be charged a **$200 cancellation fee**.
- Please do not take any naps.
- Please do not drink any caffeine after 12:00 pm.
- Please make sure your hair and skin is clean and dry. Please do not put any products in your hair or on your skin. For example; no hairspray, no gel, no mousse, no lotions, and no make-up.
- Please take all prescribed medications as usual, but avoid taking sleeping pills until you arrive.
- Please note: The technologist cannot discuss the results of the sleep study with you.



51 N. Fifth Avenue, Suite 302, Arcadia, CA 91006
Tel: 626-574-5900 / Fax: 626-574-5955

Global Sleep is on the 3rd floor of the Specialty Medical Center, near the corner of North Fifth Avenue and Huntington Drive in Arcadia, Ca.

Heading East on the 210 Freeway take the Huntington Drive exit. Turn right onto Huntington Drive. Turn right onto North Fifth Avenue. The lab is located in the Specialty Medical Center building immediately to your left.

Heading West on the 210 Freeway take the Huntington Drive exit. Turn right onto Huntington Drive. Turn right onto North Fifth Avenue. The lab is located in the Specialty Medical Center building immediately to your left.

When you arrive at the Specialty Medical Center facility, the glass front door will be locked. Please press the door bell on the right side of the front door. It will ring inside the lab and the technician will be able to unlock the door for you. Proceed to the elevators on your left and select the 3rd floor. Global Sleep is located down the hall to your right after you exit the elevator.

GLOBAL Sleep

Global Sleep Patient Demographics Form

Patient Information (Please fill out completely)

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security Number: _____

Gender: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Other

Home Address (Number and Street): _____

City: _____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Employer: _____ Employer Number: _____

Emergency Contact: _____ Emergency Phone Number: _____

Relationship to the patient: □ Self □ Spouse □ Other, Please explain: _____

Physician Information

Primary Care Physician: _____ PCP Phone Number: _____

PCP Address: _____

Referring Physician: _____ Referring Dr's Number: _____

Referring Physician's Address: _____

Insurance Information (If different from above)

Primary Insurance: _____ Customer Service Number: _____

Member ID Number: _____ Group Number: _____

Policy Holder's / Subscriber's Name: _____ Date of Birth: _____

Relationship to the patient: □ Self □ Spouse □ Other, Please explain: _____

Secondary Insurance: _____ Customer Service Number: _____

Member ID Number: _____ Group Number: _____

Policy Holder's / Subscriber's Name: _____ Date of Birth: _____

Relationship to the patient: □ Self □ Spouse □ Other, Please explain: _____

Welcome to Global Sleep, and thank you for choosing us as your provider of care. We have adopted the following statement as our financial policy which we require that you read, agree to and sign prior to receiving any services.

Payment Responsibility: You are financially responsible for charges associated with your visit. As a courtesy, and for your convenience, we bill your insurance company/companies for the services you receive. However, you are responsible for any and all annual deductibles and co-payments at the time services are rendered. Furthermore, not all insurance companies cover the services at 100%, and depending on your insurance plan, you could be responsible for a portion of the charges. Different insurances (and plan codes) pay different rates for the study which makes it difficult for us to quote how much you may be charged out of pocket. If you are uncertain of your coverage, please contact your insurance. If your insurance denies the claim you are personally responsible the balance owed on the account. If you choose not to bill your insurance for services provided, it is understood that you assume financial responsibility for all charges. Additionally, if you are seeking treatment under workman's compensation, please submit your employer authorization for treatment. In such cases, services will be provided on a self-pay basis until the authorization is received.

Methods of Payment: We accept cash, personal checks, Visa, MasterCard, Discover, and AMEX as payment for our services.

Patient Billing: Patients with outstanding balances are billed monthly. All payments are due 30 days from the billing date on the invoice. If the account balance has not been paid within 30 days, and you have not contacted the office regarding the account, your account may be referred to an independent collection agency. In that case, information that is helpful and/or necessary for collection purposes will be forwarded to our professional collection company. All costs incurred in the collection process shall be added to the original balance due.

Returned checks: There is a $25.00 fee for all returned checks. You will have 30 days from the day the check was returned to make payment in full. In this case, payment might be required to be made in cash, with a cashier's check, or a money order only. If the payment is not received within 30 days from our office contacting you, your account will be forwarded to a collection agency.

Missed Appointments: Please remember that a technologist and a private room have been reserved specifically for you and your scheduled appointment. You may be charged a fee $200.00 if you do not show up for your scheduled appointment, or if you do not call 48 hours in advance during normal business hours to cancel your appointment. This fee is assessed to cover the cost of the technologist and the facility space associated with your appointment. Insurance companies will not pay this fee.

HIPPA: Your privacy important is important to us. We ask that you please read over our HIPPA form. When you sign below, you state that you have read and understand everything about HIPPA. You may obtain a personal copy of our HIPPA form by requesting it from our office.

Video/Audio: Please note that video recording and audio monitoring are used during the study.

I, the undersigned, have read, clearly understand and agree to the provisions of this financial policy. I also authorized the release of any medical information necessary to process the claim and request, from my insurance carrier, payment of benefits to Global Sleep, LLC for the services rendered. I also authorize Global Sleep, LLC to release any information that the collection company may need to collect any outstanding debt. I also authorize Global Sleep, LLC to release any information necessary for my treatment.

Print name of the Patient	Date
Signature of Patient or Guardian	Guardian Relationship to Patient

History and Physical:

Patient's Name: _____ Height: _____

Date of Birth: _____ Weight: _____

Gender: _____ Neck Size: _____

Chief Sleep Complaint: _____ Race (optional): _____

Past Medical History:

Please answer all of the following to the best of your ability.

Asthma	□ Yes	□ No	Heartburn (GE Reflux)	□ Yes	□ No
Back Problems	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Cancer	□ Yes	□ No	Lung Disease	□ Yes	□ No
Congestive Heart Failure (CHF)	□ Yes	□ No	Parkinson's Disease	□ Yes	□ No
COPD	□ Yes	□ No	Psychiatric Disorder	□ Yes	□ No
Deviated Septum	□ Yes	□ No	Seizure	□ Yes	□ No
Diabetes	□ Yes	□ No	Shortness of Breath	□ Yes	□ No
Diagnosed Depression	□ Yes	□ No	Sinus Problems	□ Yes	□ No
Emphysema	□ Yes	□ No	Sore Throat	□ Yes	□ No
Frequent or Severe Headaches	□ Yes	□ No	Stroke	□ Yes	□ No
Heart Disease	□ Yes	□ No	Tuberculosis (TB)	□ Yes	□ No
HIV/AIDS	□ Yes	□ No	Weight Gain /Weight Loss	□ Yes	□ No

Medications:

Please list any over-the-counter and prescription medications you are taking. If you need more space, attach a separate page.

Medication Name: Dosage Times per Day

_____

_____

_____

_____

_____

_____

Allergies: (including latex allergy)

Medical Equipment:

Do you have or currently use and of the following:

CPAP Machine?	☐ NO	☐ YES	If yes, then for how long?		
Pressure setting?		cmH2O			
BIPAP Machine?	☐ NO	☐ YES	If yes, then for how long?		
Pressure setting?		cmH2O			
Heated humidifier with CPAP/BIPAP?	☐ NO	☐ YES	Use a nebulizer	☐ NO	☐ YES
Use Supplemental Oxygen?	☐ NO	☐ YES	If yes, please answer the following:		
☐ 24 hour use	☐ As	Needed	☐ Night Only	Setting:	liters

Epworth Sleepiness Scale:

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

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation:	Answer	
Sitting and reading:	_____	
Watching television:	_____	**Total**
Sitting inactive in a public place (i.e., a theater or meeting):	_____	
As a passenger in 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 traffic:	_____	

Sleep Assessment:

The following questions will help us to obtain a better understanding of your sleeping problems. Try to answer these questions as completely as possible. There are some questions that your bed partner or room-mate can be helpful with, such as those about snoring. All answers should reflect the past six months of your sleep, unless otherwise specified.

Do you usually read or watch TV before going to bed? ☐ No ☐ Yes For how long? _____ ☐ Hours ☐ Minutes

Do you use any sleep aids or medications? ☐ No ☐ Yes How often? _____

Please list the medications used: _____

How many hours of sleep so you get on average? _____ ☐ Hours ☐ Minutes

How often do you wake up: For the restroom? _____ Other? _____

How long are you out of bed for? _____ ☐ Hours ☐ Minutes

How long does it usually take to fall back asleep? _____ ☐ Hours ☐ Minutes

Do you sleep in a reclining chair, elevated bed, or a special surface?	☐ Yes	☐ No	Do you have the sensations of Paresthesia (pins and needles) in your limbs at night?	☐ Yes	☐ No
Do you have disturbed or restless sleep?	☐ Yes	☐ No	Do you sweat excessively at night?	☐ Yes	☐ No
Do you sleep with someone else in your room?	☐ Yes	☐ No	Do you sleep walk?	☐ Yes	☐ No
Do you sleep with someone else in your bed?	☐ Yes	☐ No	Do you sleep talk?	☐ Yes	☐ No
Do you disturb the sleep of your sleep partner?	☐ Yes	☐ No	Do you feel muscular tension at night?	☐ Yes	☐ No
Do you have nasal congestion at night?	☐ Yes	☐ No	Do you grind or clench your teeth at night?	☐ Yes	☐ No
Do you use a nasal spray or medication to deal with nasal congestion?	☐ Yes	☐ No	Do you awaken with the urgent need to urinate?	☐ Yes	☐ No
Do you have leg twitching or jerking during your sleep?	☐ Yes	☐ No	Do you have stomach or abdominal pains at night?	☐ Yes	☐ No
Do you have thoughts racing through your mind or feel anxious when trying to sleep?	☐ Yes	☐ No	Do you awaken with acid reflux (severe Burning in your throat)?	☐ Yes	☐ No
Do you experience pain or discomfort at night?	☐ Yes	☐ No	Do you eat during the night?	☐ Yes	☐ No
Do you have itching sensations at night?	☐ Yes	☐ No	Do you have gas or indigestion at night?	☐ Yes	☐ No
Are you afraid you will not be able to sleep?	☐ Yes	☐ No	Do you feel sad or depressed at night?	☐ Yes	☐ No