SLEEP SCIENCE CLINICS TEXAS
SLEEP DIAGNOSTICS OF NEW JERSEY

ACHC
ACCREDITED
SLEEP LAB

PATIENT REGISTRATION
AUTHORIZATION, ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patient's Name	**Sex** □ **M** □ **F**	**Birth Date** / /	**Marital Status** □ **Single** □ **Widowed**	□ **Married** □ **Divorced**
Patient's Address:		**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**		**Patient's Social Security No.**	
If employed, Name of Employer:			**Business Phone:**	
Employer's Address if applicable:			**Occupation:**	
Person Financially Responsible □ **Self** □ **Name:**	**Relationship** □ **Spouse** □ **Other**	**Resp Party's Birth date** ____/____/____	**Resp's Social Security No.**	**Resp's Phone No.**
Reason for Visit: □ **PT** □ **ENG** □ **SLEEP STUDY**	**Referring Physician:**			
	Person to Contact in Case of Emergency:			
	Relationship to Patient:		**Emergency Phone Number:**	
Primary Insurance (ID Card to be photocopied):		**Secondary Insurance (ID Card to be photocopied):**		

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefits to the Sleep Facility. above for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures

I specifically agree to pay finance charge of 1.5% per month (18% per annum) on any balance due over 90 days, and specifically agree to attorney's fees of 25% or greater, as well as all to collection, court costs and interest fees accrued with the collection of this account.

Further, I have received copies and read Sleep Diagnostics of NJ, Inc. Financial and Payment Policy and Notice of Privacy Practices.

Patient, Parent or Guardian Signature (If patient is under 18 years old) **Date**

I hereby acknowledge that I have read and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms on this form by affixing my initials.

1. **Medical Treatment**
   I do hereby consent to be tested at Sleep Diagnostics of NJ, Inc. and permit my physician, his/her technician to perform any service or routine diagnostic procedure which the physician deem necessary. I acknowledge that no guarantees have been made as to the result of the tests or examinations in the sleep lab. I also understand that it is possible that this procedure may result in mild and temporary skin irritation. In very rare circumstances skin discoloration can occur.

2. **Release of Information**
   I hereby authorize Sleep Diagnostics of NJ, Inc. to release part or all of my medical records to other Medical professions, and/or any insurance company, governmental agency managed care organization, or any other entity or person who may be required to pay all or part of the costs of my treatment and/or outpatient care.

3. **Authorize to Video Tape**
   I authorize Sleep Diagnostics of NJ, Inc. to videotape me during my sleep diagnostic study to facilitate an accurate diagnosis as to the type and severity of any sleep disorder and that all such tapes will be held in the strictest confidence and shared only with medical professionals responsible for my medical care. I understand that I will receive no compensation, whatsoever from any party for permitting such filming.

4. **Assignment of Benefits and Financial Policy**
   Insurance plans with co-insurance/co-pay are the responsibility of the patient and is collected before every treatment is performed.

5. **Personal Valuables**
   I understand that Sleep Diagnostics of NJ, Inc. its trustees, officers, employees are not responsible for loss of, or damage to, property that is kept by me in the sleep lab. I am fully responsible for all articles, jewelry, dentures, eyeglasses, etc. and clothing that I retain in my possession (in the room) and for any other articles that may be brought to me while I am a patient in the Sleep Diagnostics of NJ, Inc. clinic

6. **Privacy Practices**
   I acknowledge receipt of Notice of Privacy Practices.

Patient's Signature _____ **Date** _____

_____
(Print)

Witness _____ **Date** _____

_____
(Print)

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NAME: _____ _____ _____
FIRST NAME INITAL LAST NAME

Date of Birth: _____ Age: _____ Gender ☐ Male ☐ Female
mm/dd/yyyy YEARS

Height: Feet: _____ Inches: _____ Neck Size: _____

Tally Risk Points

Neck Size
+2 Male ≥ 16.5
+2 Female ≥ 15.0

COMPLETELY FILL IN ONE CIRCLE FOR EACH QUESTION- ANSWER ALL QUESTIONS

HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

High Blood Pressure	Yes ○ No ○	Stroke	Yes ○ No ○		
Heart Disease	Yes ○ No ○	Depression	Yes ○ No ○		
Diabetes	Yes ○ No ○	Sleep Apnea	Yes ○ No ○		
Lung Disease	Yes ○ No ○	Nasal Oxygen Use	Yes ○ No ○		
Insomnia	Yes ○ No ○	Restless Leg Syndrome	Yes ○ No ○		
Narcolepsy	Yes ○ No ○	Morning Headaches	Yes ○ No ○		
Sleeping Medication	Yes ○ No ○	Pain Medication e.g., vicodin, Oxycontin	Yes ○ No ○		

Co-morbidities
+1for each Yes response

Score ☐

Do not assign any points for these eight responses

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 mark the most appropriate box for each situation. (M.W. Johns, Sleep 1991)

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

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (theater, meeting, etc)				
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 lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Epworth Score TOTAL the values from all 8 questions,
If 11 or less **Score= 0**
If 12 or more **Score= 2**

Score ☐

Assign points for each of the first three responses

Frequency	**0- 1 times/week**	**1 -2 times/week**	**3-4 times/week**	**5 - 7 times/week**
On average in the past month, how often have you snored or been told that you snored?	Never O	Rarely O+1	Sometimes O+2	Frequently O+3	Almost always O+4
Do you wake up choking or gasping?	Never O	Rarely O+1	Sometimes O+2	Frequently O+3	Almost always O+4
Have you been told that you stop breathing in your sleep or wake up choking or gasping?	Never O	Rarely O+1	Sometimes O+2	Frequently O+3	Almost always O +4
Do you have problems keeping your legs still at night or need to move them to feel comfortable?	Never O	Rarely O	Sometimes O	Frequently O	Almost always O

☐
☐
☐

Signature

Area Code Phone Number

Total all 6 boxes from above

If point total = 4 to 5 (low risk), 6 to 10 (high) and 11 or more (very high risk)

POINT TOTAL ☐

DURABLE ASSIGNMENT OF BENEFITS
AND
PAYMENT AUTHORIZATION

Date: _____

Insurance(s):

_____

Subject: Patient Name: _____

Member ID: _____

DOB: _____

To Whom It May Concern:

I, _____, authorize payment of medical service(s) to the provider, Sleep Diagnostics of New Jersey, Inc or all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Thank you.

Effective Date of Authorization: _____

_____
(Signature)

_____
(Print Name)