At Home Sleep Studies

Phone: (702) 463-8062 • Fax: (702) 463-8368

1661 E. Flamingo Road Ste. 4-B • Las Vegas, NV 89119

Dear Home Sleep Test Patient,

Thank you for allowing At Home Sleep Studies to provide your home sleep test. Your physician has ordered this test to evaluate you for Sleep Apnea, a condition where you stop breathing during sleep. An individual with this condition may not even be aware of it. Untreated, sleep apnea can lead to excessive daytime sleepiness and fatigue, as well as serious health problems such as high blood pressure, heart problems, diabetes and stroke. However, some patients with risk factors for obstructive sleep apnea and other medical disorders may not be appropriate for a home sleep testing. **HOME TESTING IS NOT RECOMMENDED FOR THOSE WITH:** ***Central Sleep Apnea, CHF - Congestive Heart Failure, Chronic Opiate or Narcotic Use, COPD – Chronic Obstructive Pulmonary Disease, Cognitive Impairment, Emphysema, Idiopathic Hypersomnia, Epilepsy, Morbid Obesity - (BMI greater than 45), Narcolepsy, Neuromuscular Disease, Pulmonary Hypertension, Seizures, & Stroke.*** We ask patients with any of the above diagnoses to immediately notify At Home Sleep Studies staff (702) 463-8062 and we will confirm with your physician appropriateness of home sleep testing.

Please conduct and return your Home Sleep Test promptly as other patients are scheduled and waiting to be tested using the same recorder. Your physician has been notified of your scheduled sleep test and will be waiting for your final test results. This type of sleep test allows you to sleep in the comfort of your own home while a machine collects information. Go to bed at your normal bedtime and try to sleep in bed for 6 hours. If you don't get at least four hours of sleep or experience other difficulties, call At Home Sleep Studies (702) 463-8062.

IF YOU EXPERIENCE A MEDICAL EMERGENCY SUCH AS CHEST PAIN, SHORTNESS OF BREATH, NUMBNESS OR PAIN IN LEFT ARM, OR A DEBILITATING HEADACHE OR OTHER LIFE-THREATENING CONCERN, CALL 911 IMMEDIATELY.

Once you complete your home sleep test please return the device back to At Home Sleep Studies unless other pickup arrangements have been scheduled. At Home Sleep Studies provides only the diagnostic portion of your sleep study. This means you will not be seen by or be in direct communication with our sleep physicians. Your results are reviewed by our board-certified sleep specialist and the final sleep report will be faxed to your physician. Your health care provider will review the sleep study results with you and map out a plan of action for your sleep disorder and symptoms. **Do Not Call At Home Sleep Studies For Sleep Results.** ***We Recommend That You Schedule An Appointment With Your Ordering Physician One Week After Your Home Sleep Test To Review Your Results.***

You have the right to voice grievances or complaints regarding treatment or care that is (or Fails to be) furnished and lack of respect of property by anyone who is providing care on behalf of At Home Sleep Studies and will not be subjected to discrimination or reprisal for doing so. If you would like to report a grievance, complaint or concern you may file a verbal or written complaint to phone number or address above.

We make every effort to promote a quality and comfortable testing experience. We recognize that this testing may includes new experiences that you do not commonly endure when you sleep in your own home. However, we appreciate your feedback on your home sleep testing experience and look forward to working on improving our patient home sleep testing.

For additional information regarding specific sleep disorders, we recommend visiting **www.sleepeducation.com**

Thank you

At Home Sleep Studies

HOME SLEEP TESTING

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Portable Sleep Study Equipment Release & Responsibility Form

I, the undersigned, certify that I am the recipient of Portable Sleep Study Equipment Recorder/Unit with the following description: **Brand & Model: ☐ RESMED APNEALINK PLUS/AIR (Home Sleep Test)**

☐ RESPIRONICS PULSE OXIMETER 920M PLUS

Serial Number: _____

I received adequate instructions on proper use of above Portable Sleep Study Equipment Recorder/Unit and understand them fully.

I understand that I am responsible for the proper care of above Portable Sleep Study Equipment Recorder/Unit while it is in my possession. If I return the device damaged for whatever reason I will be charged the full replacement value in the amount of $2,500.00 (Two Thousand Five Hundred Dollars).

I AGREE TO RETURN ABOVE PORTABLE SLEEP STUDY EQUIPMENT RECORDER/UNIT PROMPTLY TO THE ADDRESS AND ON THE DATE SHOWN BELOW.

Address: 1661 E Flamingo Road Suite 4B; Las Vegas, NV 89119

Return/Due Date:_____

I understand that if for whatever reason I am unable to return the device to the above mentioned address and on the due date, I will contact and notify At Home Sleep Studies prior to the due date.

I understand that if I do not return the device on the due date above and Fail to promptly notify At Home Sleep Studies, I will be charged a FEE of $50.00 per day and/or the full replacement value in the amount of $2,500.00 (Two Thousand Five Hundred Dollars).

I further understand that my credit card account will not be charged if I return the device as stipulated on this Portable Sleep Study Equipment Release & Responsibility Form.

I, the undersigned, have read and completely understand Portable Sleep Study Equipment Release & Responsibility Form.

_____	_____	_____
(Patient Signature)	(Print Name)	(Date)
_____	_____	_____
(Employee Signature)	(Print Name)	(Date)

PATIENT INFORMATION

Patient Name: _____
Last First Middle

DOB: _____/_____/_____ **Social Security #:** _____ **Gender:** ☐ **Male** ☐ **Female**

Insurance Policy Holder: _____
Last First Middle

DOB: _____/_____/_____ **Social Security #:** _____ **Relation:**_____

Address:_____
Street City State Zip Code

Home #: (_____)_____ **Cell #: (_____)**_____ **Email:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Spouse's Name:**_____

Emergency Contact:_____ **Phone #: (_____)**_____

Employer:_____ **Phone #: (_____)**_____

Referring Physician:_____ **Phone #: (_____)**_____

Primary Care Physician:_____ **Phone #: (_____)**_____

Do You Participate With A Flexible Spending Account For Medical Payments? ☐ **YES** ☐ **NO** **If YES, Amount: $**_____

Do You Participate With Any Employer Health Contribution Account Program? ☐ **YES** ☐ **NO** **If YES, Amount: $**_____

PATIENT AGREEMENT

☒_____ I certify that I and/or my dependents(s) have insurance coverage with _____ as primary and secondary insurance(s). I assign directly to At Home Sleep Studies LLC all insurance benefits, if any, otherwise payable to me for services rendered by At Home Sleep Studies LLC. My signature authorizes At Home Sleep Studies LLC to submit their diagnostic sleep claims to my insurance.

☒_____ I understand At Home Sleep Studies is billing my insurance as a courtesy to me. I authorize the use of my health care information and the disclosure of information to the above named Insurance company(ies) and their agents for the purpose of obtaining payment for sleep services, determining insurance benefits, or benefits payable for related services. I also understand it is my responsibility to follow up with my insurance company 30 days from date of service to make sure they are processing my claims. Any claims not paid within 90 days will be my responsibility. This consent will end when my current treatment plan is completed or one year from the date signed below.

☒_____ I understand At Home Sleep Studies will charge me $200.00 for an unexcused No-Show or Cancellation with less than 48 hours of my scheduled appointment. The No-Show and Cancellation fee is NOT a covered benefit with Medicare or your insurance provider.

☒_____ I understand that I am financially responsible for all charges whether or not paid by my insurance. I am ultimately responsible for the balance of my account for any sleep diagnostic services rendered. If my account becomes delinquent, I agree to pay interest on the outstanding balance owed at the maximum amount permitted by law and if At Home Sleep Studies undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees. I request that payment of authorized medical benefits be paid directly to At Home Sleep Studies.

Patient Signature:_____ Date:_____

Patient Consent

Phone: (702) 463-8062 • Fax: (702) 463-8368

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At Home Sleep Studies, LLC is a CMS approved Independent Diagnostic Testing Facility (IDTF) that performs Diagnostic Sleep Testing to include but not limited to PSG, PAP Titration, ASV Titration, Split-Night Sleep Testing, Pediatric PSG, Pediatric Titration, Home Sleep Testing, and Pulse Oximetry Testing services. Should you have any questions please contact us at **(702) 463-8062**.

The undersigned, understands and agrees that the Diagnostic Sleep Testing just performed or about to be performed, was ordered by your physician for the purpose of measuring your sleep disorder and verifying your need for home sleep disorder breathing equipment as it pertains to your disease or condition. Further, I hereby authorize At Home Sleep Studies, LLC to bill my insurance carrier or Medicare on my behalf for the costs of this test. I understand that I may be financially responsible for a deductible or co-pay and agree to make such payment if it is determined that my deductible or co-payment have not been met at the time of service. If I am deemed ineligible by Medicare or other insurance carriers to which At Home Sleep Studies, LLC submits a claim on my behalf or should my insurance company/responsible billing party not pay for the services provided, I agree to pay all charges incurred. I certify that I am the recipient of the testing described herein, and that the test was actually performed on me. I hereby authorize At Home Sleep Studies, LLC to release information concerning this test and any medical information necessary, to the provider(s) of my medical care such as physicians, medical equipment company, or hospital – as well as any insurance company or responsible billing party. This information may include diagnosis, records of any treatment, or any examinations rendered.

AUTHORIZATION TO DICSLOSE HIPAA PROTECTED HEALTH INFORMATION

I authorize At Home Sleep Studies, LLC, who will be processing the data from my Diagnostic Sleep Testing report(s), to release the report(s) to the physician who ordered the test and to the DME provider who may be supplying your equipment, to gather the data for the purposes of monitoring my sleep disorder. I understand that if information is disclosed under the authorization to someone who is not a health care provider, the information may no longer be protected by federal privacy rules and could be disclosed to others by the recipient. I understand I have the right to refuse to sign below related to Authorization to release sleep diagnostic testing results or obtain Medical Records, and I also understand that I have the right to revoke this authorization at any time with written notice or revocation to At Home Sleep Studies, LLC, (except to the extent that At Home Sleep Studies, LLC has taken action in reliance on the authorization and information has already been released).

PATIENT HEALTH INFORMATION CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION PRIVACY STATEMENT

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out the treatment, payment activities, and healthcare options.

Notice of Privacy: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare options of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. Below is a notice of this consent in which we encourage you to read carefully and completely before signing.

AUTHORIZATION TO DISCLOSE HIPAA PROTECTED HEALTH INFORMATION

Please note that we maintain paper and electronic files that may contain private information about that may include, but is not limited to your name, date of birth, address, phone number, contact person, height and weight, diagnosis, prognosis, physician's prescriptions, plans of services and treatment, vital signs, clinical impressions, insurance coverage(s), equipment rented and purchased, credit card number, dates of services, etc. We release, transfer and disclose the above information to the third parties to facilitate appropriate provision and review of services and billing for our clients of record. These files are legal documents and are also used for education, evaluating the performance of our organization, marketing, and planning purposes. We have measures in place to protect patient health information as required by law. These measures include, but are not limited to, security precautions being in place in our building, vehicles, billing software, transactions of data to third-parties, telephonic and wireless communications, maintenance, retention and destruction of data, etc. You have the right to amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file, and have released to others upon request. If you have questions concerning any of the above, please contact our Compliance Officer at **(702) 463-8062**.

PATIENT RIGHTS AND RESPONSIBILITIES

Be fully informed in advance about care/service to be provided, the disciplines that furnish care, the frequency of visits and any modifications to the plan of care. Be informed, both orally and in writing, in advance of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible. Receive information about the scope of services that the organization will provide and specific limitations on those services. Refuse care or treatment after the consequences of refusing care or treatment are fully presented. Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality. Be able to identify personnel members through proper identification. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of client/patient property. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal. Have grievances/complaints regarding treatment or care that is (or fails to be) furnished, or lack of respect of property investigated. Confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information. Be advised on agency's policies and procedures regarding the disclosure of clinical records. Choose a health care provider, including choosing an attending physician. Receive appropriate care without discrimination in accordance with physician orders. Be informed of any financial benefits when referred to an organization. Be fully informed of one's responsibilities.

I have had full opportunity to read and consider this consent form and I have received At Home Sleep Studies Notice of Privacy Practices. I understand that, by signing this consent form, I am giving consent to At Home Sleep Studies for use and disclosure of my protected health information (PHI) to carry out treatment, payment activities and healthcare or referral operations.

Patient Signature **Date**

NOTICE OF PRIVACY PRACTICES

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.

As a customer of At Home Sleep Studies, LLC, you are entitled to certain services provided under the direction of your physician. In the course of providing these services to you, we may receive and exchange medical information necessary in the continuation of care. Federal law requires we protect the privacy of your medical information, which includes, but may not be limited to, information that identifies you and relates to your past, present, or future health or condition, the provision of health care to you, or payment for services received by you. At Home Sleep Studies, LLC, may exchange Protected Health Information (PHI) with other companies (Business Associates) to assist in providing these services to you.

Federal Law requires we provide you with this notice about its privacy practices and its legal duties regarding your medical information. This notice explains how, when, and why At Home Sleep Studies, LLC, may use and disclose your medical information. We may change our privacy practices and the terms of this notice at any time. Changes will be effective for all of your PHI. If the privacy practices changes, we will mail you a new notice of privacy practices that incorporates any changes within sixty (60) days.

Certain uses and disclosures do not require your written permission. At Home Sleep Studies, LLC, may use and disclose your medical information without your written permission for the following purposes:

For services/treatment; to obtain payment for services/treatment; for health care operations; to you and your personal representative; when a disclosure is required by law; to Business Associates.

For other uses and disclosures permitted by law:

- To public health authorities for public health purposes
- To state agencies handling cases of abuse, neglect, or domestic violence
- To a government agency authorized to oversee the health care system or government programs
- To comply with legal proceedings, such as a court or administrative order or a subpoena
- To law enforcement officials for limited law enforcement purposes
- To a coroner, medical examiner, or funeral director about a deceased person
- To an organ procurement organization in limited circumstances
- To avert a serious threat to your health or safety or the health or safety of others
- To military authorities if you are a member of the armed forces or a veteran of the armed forces
- To federal officials for lawful intelligence, counter-intelligence, and other national security purposes
- To an executor or administrator of your estate
- To any other persons and or entities authorized under law to receive medical information

ALL OTHER USES AND DISCLOSURES REQUIRE YOUR PRIOR WRITTEN PERMISSION

Any other use or disclosure of your medical information At Home Sleep Studies, LLC, must have your written permission. You may cancel your written permission for the use and disclosure of any and/or all of your medical information, however we may complete any action initiated prior to revocation, and which rely on release/exchange of PHI for completion.

YOUR RIGHTS

You may make a written request to us to do one or more of the following concerning your PHI received by us or our Business Associates:

- Add additional limitations on the uses and disclosures of your medical information
- Choose how we send PHI to you
- See and get copies of your PHI
- Get a list of certain uses and disclosures of your PHI
- Get a copy of this notice
- File a complaint if you think we have violated your privacy rights regarding your PHI

Although At Home Sleep Studies, LLC, will utilize its best efforts to comply with your request, we may legally deny your request in certain circumstances. We will notify you of the reason for the denial and you will get a chance to respond. We may not deny a request to communicate with you in confidence by a different means or location if the current means or location used by us endangers you. Your request to communicate by a different means or location must be in writing, include a statement that disclosure of all or part of the PHI by the current means could endanger you, and specifically state the different means or location by which you would like us to communicate with you. If you believe your privacy or security rights have been violated, you can file a complaint with AHSS Privacy & Compliance Officer or with the Secretary of Health & Human Services or the Office for Civil Rights. We will not retaliate against your for filing a complaint. to the following address:

At Home Sleep Studies LLC
Privacy & Compliance Officer
1661 E. Flamingo Rd. #4B
Las Vegas, NV 89119
(702) 463-8062
athomesleepstudies@ymail.com

Secretary of Health & Human Services of Nevada
4126 Technology Way, Suite 100
Carson City, Nevada 89706
Phone: (775) 684-4000
Email: nvdhhs@dhhs.nv.gov

ACHC
139 Weston Oaks Ct.
Cary, NC 27513
Phone 855-937-2242
Local 919-785-1214
Email: customerservice@achc.org

Michael Leoz, Regional Manager
OFFICE FOR CIVIL RIGHTS
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Patient Financial Responsibility Disclosure Statement

Phone: (702) 463-8062 • Fax: (702) 463-8368

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"Everyone Deserves Restful Sleep"

PAYMENT ARRANGEMENTS

- I agree to be responsible for payment of all services rendered to me or my dependents by At Home Sleep Studies.
- By signing this document, I authorize the assignment to At Home Sleep Studies for all payments under any insurance benefits otherwise payable to me for services provided by At Home Sleep Studies under any insurance policy (Hospitalization, Major Medical, Workers' Compensation, or Any Other Insurance or Benefit Plan).
- By signing this document, I authorize the release of my protected health information (PHI) to my insurance company (ies) or other third party payer's, including their representatives, as necessary to determine coverage or as required for review, quality improvement, and/or management.
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services not covered by my insurance.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that past due accounts will be referred to a collection agency and that I will be responsible for all collection charges, associated legal fees, and the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.
- Your signature below forms a binding agreement between At Home Sleep Studies LLC (the provider of diagnostic sleep testing services) and You, the Patient, who is receiving diagnostic sleep testing services, or the Responsible Party (individual who is financially responsible for payment of medical bills).

AS THE RESPONSIBLE PARTY, YOU ARE RESPONSIBLE FOR PAYMENT IF YOUR INSURANCE COMPANY DECLINES TO PAY FOR ANY REASON OR REMITS PAYMENT DIRECTLY TO YOU, THE PATIENT.

Example: If Blue Cross Blue Shield (BCBS) sends payment directly to you, the Patient, for services rendered by At Home Sleep Studies LLC , it is your responsibility to contact At Home sleep Studies LLC at (702) 463-8062 and sign over the insurance issued check.

RETURN CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $35.00 Service Charge. Once notice is received of the returned check, At Home Sleep Studies LLC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date, the account may be turned over to our collection agency or legal services and a collection fee will be added to the outstanding balance in addition to the $35.00 Check Service Charge.

NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect on an overdue account, or failure to sign over insurance issued check, the Patient or the Patient's Responsible Party understands that At Home Sleep Studies LLC has the right to disclose to an outside collection agency or legal services, all relevant personal and account information necessary to collect payment for diagnostic sleep services rendered. The Patient or the Patient's Responsible Party, understands that they are responsible for all costs of collection or legal services including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving diagnostic sleep services, or as the Patient's Responsible Party. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____/_____/_____

Patient or Responsible Party Signature **Date**

At Home Sleep Studies

Authorization for Treatment

Phone: (702) 463-8062 • Fax: (702) 463-8368

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"Everyone Deserves Restful Sleep"

AUTHORIZATION FOR TREATMENT

I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care.

- CONSENT FOR TREATMENT: I, the undersigned, request and authorize At Home Sleep Studies LLC and all its physicians, RPSGTs, sleep technicians, and other qualified personnel, whether employed directly by At Home Sleep Studies LLC or brought in on a consulting basis, to provide diagnostic sleep testing services which my attending physician or designee(s) may deem necessary or beneficial for my health. I also understand that the results of any diagnostic sleep testing/treatment care cannot be guaranteed. I have the right to refuse any treatment or procedures to the extent permitted by law.
- I understand that I authorize my treating providers, At Home Sleep Studies LLC, to order any ancillary services deemed necessary for my care and treatment.
- I understand that video and audio recordings are made if conducting In-Facility Diagnostic Sleep Testing.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions concerns.
- I understand that medical, nursing, and other health care personnel in training may be observing and participating actively in my care under the supervision of authorized personnel. I hereby give my consent to such observations and/or participation.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transit HIV (Human Immunodeficiency Virus), Hepatitis B Virus, or Hepatitis C Virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by the state law.
- I understand that At Home Sleep Studies LLC utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations; I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.
- RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I understand that I take all possible precautions to protect my property during my stay. I release At Home Sleep Studies of all responsibility for valuables not deposited for safe keeping or for articles lost or damaged that I choose to keep in my personal possession during my In-Facility diagnostic sleep test, therapy treatment or stay with At Home Sleep Studies LLC.
- Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

I consent to the procedure and medical treatment for myself or for the patient, whom I am either the parent of or authorized legal representative. I understand my signature below confirms acceptance of the terms of this consent.

_____

Signature of Patient Date

_____

Signature & Relationship of Legally Authorized Representative Date

Consent for Treatment

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CONSENT FOR TREATMENT

Polysomnogram is a diagnostic sleep study which records detailed information while you sleep. A technician will attach sensors to monitor your: Brain Waves • Heart Rate • Breathing Rate • Oxygen Level • Eye/Leg Movements • Chin Movement

Home sleep testing (type III device) is capable of recording up to five channels of information: Respiratory Effort • Pulse• Oxygen Saturation • Nasal Flow • Snoring.

At Home Sleep Studies LLC will use this information to prepare a detailed report about your sleep. The doctor who ordered and sent you to our sleep center will receive a copy of this report. He or she will then discuss and review results with you.

Risks: *There Is No Major Health Risk Involved With In-Lab Or Home Diagnostic Sleep Study.*

Agreement: My Signature Below Indicates That I Understand And Agree With The Following Statements:

1. Diagnostic sleep study In-Lab or Home may not detect the cause or reason for your sleep disorder or sleeping concern.
2. A technician will attach sensors to different areas of my body to obtain sleep data for In-Lab diagnostic sleep study.
3. Sensors may smell bad when placed on my body and may cause redness/discoloration of skin during morning removal.
4. Skin with reduced tolerance "Sensitive Skin" may develop a skin irritation or rash. This may include stinging, itching, burning, redness, dryness, scaling, peeling, bumps, hives or discoloration.
5. Video camera will record me as I sleep. A technician will watch me on a monitor to ensure my comfort & safety as I sleep and conduct my In-Facility diagnostic sleep test, therapy treatment or stay with At Home Sleep Studies LLC.
6. I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical or educational purposes or in the event of legal action. At Home Sleep Studies LLC and all its physicians, RPSGTs, sleep technicians, and other qualified personnel and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s), and/or video recordings. No use of the material for education purposes will identify me by name.
7. I will be free to roll over and move in bed during In-Lab or Home diagnostic sleep study.
8. I will ask for help if I need to get out of bed for any reason during my In-Facility diagnostic sleep test.
9. Technician may need to enter the room to wake me for technical reasons during my In-Facility diagnostic sleep test.
10. 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 a treatment device. This treatment is called positive airway pressure, or PAP. To use this treatment, I will wear a mask that covers my nose, my nose and mouth or cushion/pillow between my nose and mouth.
11. I understand why I am taking and having a diagnostic sleep study.
12. I understand what is going to happen during the sleep study and the sleep center staff explained the procedure to me.

I consent to the procedure & medical treatment for myself or for the patient, whom I am either the parent of or authorized legal representative. I understand my signature below confirms acceptance of the terms of this consent.

_____

Signature of Patient Date

_____

Signature & Relationship of Legally Authorized Representative Date

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"Everyone Deserves Restful Sleep"

How Your Sleep Affects You

According to the National Sleep Foundation, more than 50 million Americans suffer from a sleep disorder. These disorders significantly affect: **Concentration, Attention,** & **Memory**. They are more likely to suffer from psychiatric disorders like **Depression** and **Anxiety**. They are at greater risk for **High Blood Pressure**, **Cardiac Arrhythmias**, **Diabetes**, **Stroke**, and **DEATH**.

The significant health consequences of sleep disorders have led experts to agree that these problems warrant medical attention

Prevalence of OSA
- 1 in 5 adults has mild OSA
- 1 in 15 has moderate to severe OSA
- 9% of middle-aged women
- 25% of middle-aged men
- 75% of severe SDB cases remain undiagnosed

Increased Risk Factors for OSA
- Male gender
- Obesity (BMI > 30)
- Diagnosis of hypertension
- Family history of OSA
- Upper airway or facial abnormalities
- Large neck circumference (>17" men; >16" women)
- Excessive use of alcohol or sedatives
- Smoking
- Endocrine and metabolic disorders
- Increasing age

Comorbid Associations with OSA
- Hypertension
- Cardiovascular diseases
- Stroke
- Type II diabetes
- Mood disorders (anxiety and/or depression)
- Increased morbidity
- Obesity

Cardiovascular Links
- 4.7 million people in the US have heart failure
- Approximately 50% of HF patients have SDB
- Arrhythmias noted in 50–75% of OSA patients
- 30% in cardiovascular patients
- OSA presents in 70% of heart attack patients with AHI 5
- 52% of heart attack patients with AHI > 10

Hypertension Links
- Sleep apnea is an independent risk factor for hypertension
- 30–80% of patients with hypertension have sleep apnea
- 43% of patients with mild OSA
- 49% of patients with severe OSA have hypertension

Links to Type II Diabetes
- 50% of diabetes sufferers have sleep apnea
- OSA may have a causal role in the development of diabetes
- OSA is associated with insulin resistance
- 30% of patients presented to a sleep clinic have impaired glucose intolerance
- Mild forms of SDB may help predict risk of pre-diabetes

Stroke Risk
- 65% of stroke patients have SDB
- Up to 70% of patients in rehabilitation therapy following stroke have significant SDB (AHI > 10)

Mortality Links
- SDB is associated with a 3-fold increase in mortality risk
- There is an independent association of moderate to severe OSA with increased mortality risk

Health Care Costs
(Economic consequences of untreated SDB)
- Undiagnosed patients used $200,000 more in the two -year period prior to diagnosis
- Prior to sleep apnea diagnosis, patients utilized 23–50% more medical resources
- Total economic cost of sleepiness is around $43–56 billion
- Undiagnosed sleep apnea in middle-aged adults may cause $3.4 billion in additional medical costs in the US

Traffic Accidents
- 15-fold increase of being involved in traffic accident
- People with sleep apnea are at twice the risk of having a traffic accident
- Treating all US drivers suffering from sleep apnea would save $11.1 billion in collision costs & 980 lives annually

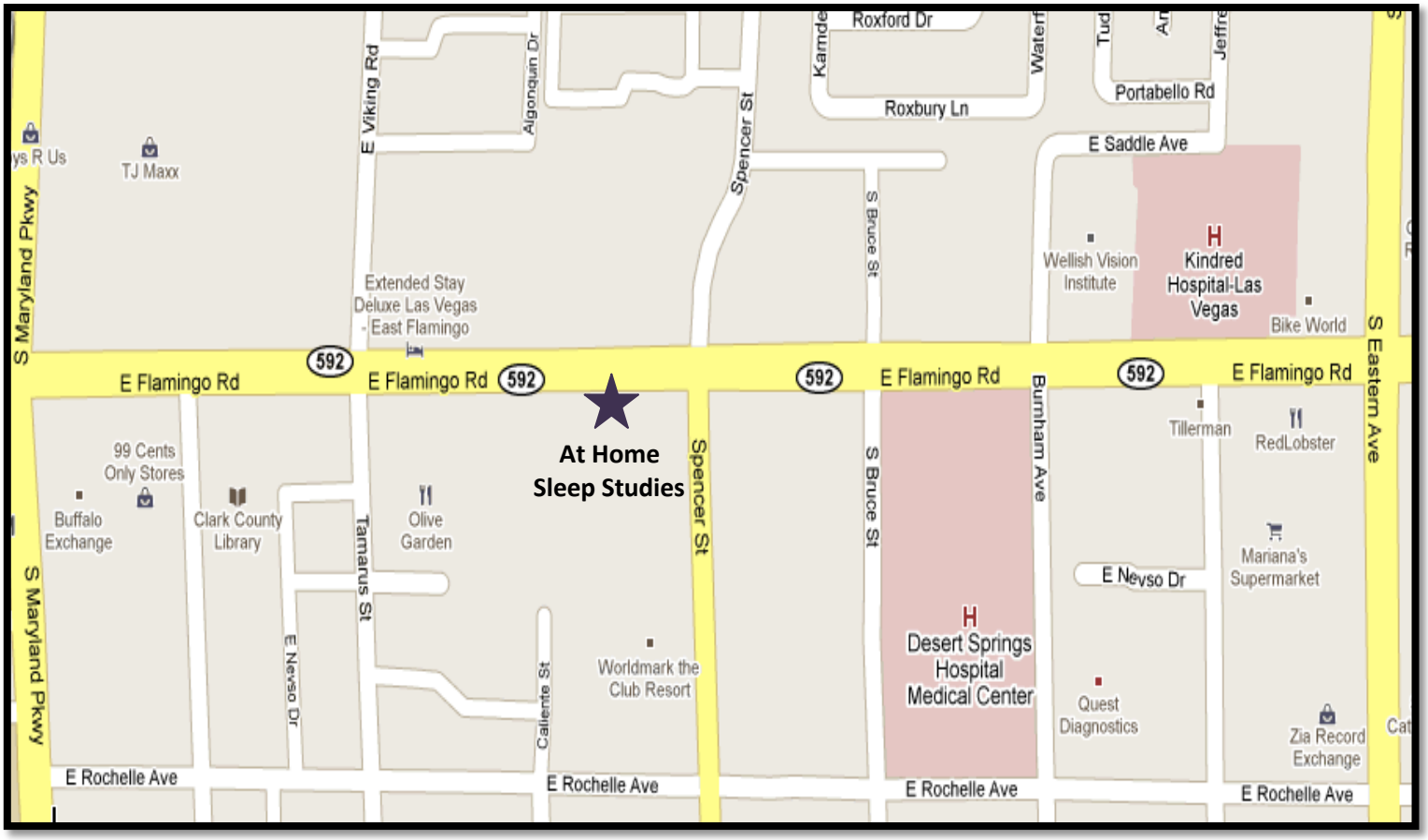
Signs and Symptoms of OSA
- Lack of energy • Morning headaches• Hypertension
- Diabetes• Frequent nocturnal urination • Depression
- Obesity • Large neck size • Gastroesophageal reflux
- Excessive daytime sleepiness• Nighttime gasping

Location Information Sheet

Phone: (702) 463-8062 • Fax: (702) 463-8368

1661 E. Flamingo Road Ste. 4-B • Las Vegas, NV 89119

"Everyone Deserves Restful Sleep"



We are located on the south side of Flamingo Road inside **<u>Cambridge Quail Property</u>** (Blue & White Sign) between Spencer and Maryland Parkway.

This is a one story red brick building with a lot of trees. Our suite is located on the left side of the complex.

At Home Sleep Studies, LLC
1661 E. Flamingo Road, Suite #4B, Las Vegas, NV 89119

Name (First):_____ (MI)_____ (Last)_____

Age:_____ Weight:_____ Height:_____ Neck Size:_____inches Occupation:_____

EPWORTH SLEEPINESS SCALE (0 – 3)

0 = would never feel sleepy
1 = *slight* chance of being sleepy
2 = *moderate* chance of being sleepy
3 = *high* chance of being sleepy

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (meeting, theater)	_____
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 eating lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total Points	_____

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

MY MAIN SLEEP COMPLAINT(S)

- ❑ Trouble sleeping at night for how long months:_____ and years_____
- ❑ Being sleepy all day for how long months:_____ and years_____
- ❑ Snoring for how long months:_____ and years_____
- ❑ Unwanted behaviors during sleep for how long months:_____ and years_____
  Explain Behavior:_____
- ❑ Other, Explain:_____

SLEEP HABITS

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ 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 have trouble falling asleep
- ❑ 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 a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

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

RESTLESSNESS

- ❑ I have uncomfortable feelings in my legs and/or arms during sleep
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I 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

DAYTIME SLEEPINESS

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember clearly what 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 sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up

HABITS

Do you smoke? ❑ Yes ❑ No **IF YES: What Type and Amount Per Day For How Many Years**

❑ Cigarettes _____ pack(s) _____ years

❑ Cigars _____ cigars _____ years

❑ Tobacco _____ pipes _____ years

Do you drink alcohol? ❑ Yes ❑ No **IF YES: What Type and Frequency Amount Per Week**

❑Beer ❑Daily ❑Weekends ❑Rare _____ cans/week

❑Wine ❑Daily ❑Weekends ❑Rare _____ glasses/week

❑Liquor ❑Daily ❑Weekends ❑Rare _____ shots/week

PAST SLEEP EVALUATION AND TREATMENT

❑ I have had a previous sleep disorder evaluation or been previously treated for a sleep disorder

❑ I have had previous overnight sleep studies ❑ In-Lab ❑ Home Sleep Test ❑ Pulse Oximetry

❑ My last overnight sleep study was ❑ When:_____ ❑ Where:_____

❑ I have had daytime nap studies

❑ I currently use home Oxygen Your Oxygen Setting/LPM:_____

❑ I currently use PAP equipment for home use ❑ CPAP ❑ BiPAP ❑ ASV Your PAP Settings:_____

❑ I have had surgical treatment for a sleep disorder ❑ Year of Surgery:_____

❑ I have previously been prescribed medication for a sleep disorder

❑ I have taken Sleeping Aids for sleeping or helping stay awake. Did Sleeping Aid Work? ❑ Yes ❑ No

GENERAL

- ❑ I sleep with someone else in my bed/in my room
- ❑ I fall out of bed while asleep
- ❑ I wet my bed
- ❑ I walk in my sleep
- ❑ I grind my teeth
- ❑ I have dreams
- ❑ I feel afraid I won't return to sleep after awakening
- ❑ I have a very hard time waking up
- ❑ I wake up screaming, violent or confused
- ❑ I depend on an alarm clock to wake up
- ❑ I wake up with a headache
- ❑ I wake up nauseous (sick to my stomach)
- ❑ I wake up with a dry mouth
- ❑ I wake up 1 or 2 hours before I have to get up

MY SLEEP IS FREQUENTLY DISTURBED BY (CHECK ALL THAT ARE TRUE)

❑Asthma	❑Heat	❑Cold	❑Light	❑Noise	❑Noise or Movement of Bed Partner
❑Cough	❑Hunger	❑Thirst	❑Need To Urinate	❑Choking Indigestion, "Gas" or Heartburn	
❑Chest Pain	❑Frightening Dreams		❑Shortness of Breath	❑Creeping, Crawling, Or Aching Feeling	

HEALTH HISTORY

Has your weight changed recently? ❑Yes ❑No IF YES, explain:_____

Please check any condition or illness you have or had:

☐ Allergies	☐ Depression	☐ Hemophilia (Bleeder)	☐ MRSA
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Muscle Cramps
☐ Asthma	☐ Dizziness	☐ Hernia	☐ Pneumonia
☐ Atrial Fibrillation	☐ Eye Trouble	☐ High Blood Pressure	☐ Prostate Trouble
☐ Back Trouble	☐ Fainting	☐ HIV/AIDS	☐ Ringing of the Ears
☐ Black Outs	☐ Gout	☐ Impotence	☐ Seizures
☐ Bladder Trouble	☐ Headaches	☐ Insomnia	☐ Stroke
☐ Bronchitis	☐ Hearing Trouble	☐ Kidney Trouble	☐ Tuberculosis
☐ Cancer	☐ Heart Attack	☐ Low Blood Pressure	☐ Ulcers
☐ CHF	☐ Heart Disease	☐ Meningitis	☐ Venereal Disease
☐ COPD	☐ Heartburn/GERD	☐ Mental Problems	☐ Other:_____

SURGERIES AND HOSPITALIZATIONS

Please list any hospitalizations and/or surgeries you have had. PLACE THE LATEST FIRST: include where, what, why, and when.

_____

_____

_____

_____

_____

CHECK ONE BOX FOR EACH STATEMENT OF USAGE

		Never	Sometimes	Often
A.	Marijuana	❑	❑	❑
B.	Cocaine	❑	❑	❑
C.	Hallucinogens (LSD, Mescaline, Angel dust, etc.)	❑	❑	❑
D.	Stimulants (uppers)	❑	❑	❑
E.	Depressants (downers)	❑	❑	❑
F.	Narcotics (heroin, morphine, opium, etc.)	❑	❑	❑

Please list the name and dose (in mg) of all medications that you take **now** or **within the past 30 days**:

Medication	Dose	What for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the past.

Name	Did it help?
_____	❑Yes ❑No
_____	❑Yes ❑No

BED PARTNER QUESTIONNAIRE

Name of Patient:_____

Name of person filling out this form: _____

I have observed this person's sleep: ❑ Never ❑ Once or Twice ❑ Often ❑ Every Night

Check any of the following behaviors that you have observed this person doing **while asleep**:

- ❑ Light snoring
- ❑ Loud Snoring
- ❑ Occasional loud snorts
- ❑ Choking
- ❑ Pauses in breathing
- ❑ Twitching or kicking of the legs
- ❑ Bed Wetting
- ❑ Biting tongue
- ❑ Twitching or jerking of the arms
- ❑ Crying Out
- ❑ Head rocking or banging
- ❑ Sitting up in bed not awake
- ❑ Awakening with pain
- ❑ Getting out of bed but not awake
- ❑ Becoming very rigid and/or shaking even if s/he behaves otherwise
- ❑ Other:_____

Please describe the other sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?
❑ Yes ❑ No If yes, please explain:

_____