Cancellation and No-Show Policy

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

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

Dear Scheduled Patient:

At this time, you have been scheduled for an overnight sleep study at our facility. A private room has been reserved in your name and coordinated arrangements have been made with a variety of people involved with your sleep study including Sleep Technologists, Scoring RPSGT Technologists and Interpreting Physicians. ***Many costs are being incurred to properly plan and perform your sleep study before you even arrive at our facility.*** We do not double book any of our patient rooms.

If you need to cancel or reschedule, we certainly understand and we will make every effort to accommodate your scheduling needs. **Notify At Home Sleep Studies During Normal Business Hours At Least 48 Hours In Advance Before Your Sleep Study.** Normal Business Hours: 9AM to 5PM Monday through Friday. By doing so, you will incur no costs for cancellation. However, if you do not cancel 48 hours prior to your appointment or No Show for your appointment, a fee of $200 will be billed to you. **Cancellation Fees or No-Show Fees are YOUR responsibility and cannot be billed to your insurance company.** Medicare and Insurance Providers Do Not Cover or Pay for Cancellation or No-Show Fees.

You Will Be Personally Responsible For This Fee of $200.

No Show Patients Will Be Required To Place A Security Deposit To Schedule Future Appointments.

ALL PATIENTS WHO CANCEL WITH LESS THAN 48 HOURS WILL BE CHARGED $200.
ALL PATIENTS WHO NO-SHOW WILL BE CHARGED $200.

Most people are considerate in providing us with advance notice and courteous to fellow patients awaiting appointments. This policy is in place due to the unfortunate fact that we continue to encounter patients who cancel at the last minute or No Show for their scheduled appointment. We are making every effort to be "up front" and clear about our cancellation policy so there is no misunderstanding. We certainly understand that situations arise and patients need to change appointments. We are happy to work with you to reschedule your appointment. All we ask is that you give us enough advance notice. If you have any question please call us at (702) 463-8062. Thank you for allowing us the opportunity to participate in your medical care. Our diagnostic team will provide you with the highest level of personal, professional, and quality care. We hope your overnight stay with at our facility will be a comfortable and pleasant experience. We sincerely appreciate your consideration and cooperation.

Sincerely,

At Home Sleep Studies Staff

Patient Information Sheet

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

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

How to Prepare

DO Shower and wash your hair and body before coming to the sleep facility.

DO NOT - wear make-up, hairspray, gel, mousse, nail polish, or apply lotions or oils to your skin or hair. They interfere with head & body sensors. Please make sure hair is dry.

DO NOT - spray or utilize perfume or cologne. At Home Sleep Studies is a diagnostic lab that provides sleep care for patients with **Compromised Respiratory Systems** or **Fragrance Sensitivity.** We don't want to put anyone in respiratory distress or failure.

DO Eat a regular dinner or meal as usual. (You may bring necessary snacks to the sleep facility)

DO NOT - drink alcohol or caffeine 8 hours prior to your sleep test. (Please do not consume too much coffee or soda.) Avoid drinking too much fluid before the study.

DO Take your regular medications including sleep aids as instructed by your physician.

DO NOT - forget to bring all medication(s) taken at bedtime or during the night.
DO NOT - take your sleep aid at home. Bring and take sleep aid at our sleep facility.

DO Bring or wear nightclothes or some comfortable sleepwear. Pajamas or shorts and a T-Shirt are preferred at the sleep facility.

DO NOT - wear satin or silky materials. Patients will not be allowed to sleep naked or only in their undergarments. All patients MUST wear clothes!

What to Expect

When you arrive for your study, the technologist will apply the monitoring devices. This should take approximately 45 minutes. You will sleep in a private bedroom, and are able to get up as much as you need throughout the night to use the restroom. Your room has a TV you are welcome to watch as you prepare for sleep. You are also welcome to bring a book or magazine. We provide bedding, including sheets, blankets and pillows. The study usually ends between 4 am and 5 a.m. the following morning. The technologist is not permitted to discuss your test results or make any treatment recommendations. Please follow up with your ordering medical provider to discuss the results of your sleep test. Results will be available after fourteen business days. In addition, we accept all major credit cards, checks, or exact cash. Sorry we are unable to make change. Thank you for your patience while we prepare for your sleep care services.

PLEASE BE ADVISED WE HAVE A 48 HOUR CANCELLATION POLICY

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 & Confidentiality

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

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

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** or access our website **athomesleep.com** to review or print information.

The undersigned, understands and agrees that the Diagnostic Sleep Testing just performed or about to be performed, was ordered by your medical provider 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 or Responsible Party 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

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 payers, 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 an outside agency and that I will be responsible for any additional 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) or any Insurance Provider sends payment directly to you, the Patient, for Diagnostic Sleep 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 Insurance Issued Check.

RETURN CHECK POLICY

If 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 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. You acknowledge and agree that At Home Sleep Studies will necessarily incur direct and indirect costs and expenses as a result of any failure by you to make prompt and timely payment for services provided. Accordingly, and to the extent the law allows, in the event your account becomes more than 60 days delinquent, you agree we may add a late fee of 35% to any unpaid amount of your account to offset the additional costs we will incur to recover your outstanding medical bill.

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**

Authorization for Treatment

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

AUTHORIZATION FOR DIAGNOSTIC SLEEP SERVICES

I hereby authorize medical treatment by the physician, 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, & 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 or treatment (In-Lab or Home Sleep Testing) 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. Example: Durable Medical Equipment
- I understand that video and audio recordings are made *If Conducting In-Facility Diagnostic Sleep Testing Only*.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider(s) and to ask and have answered to my satisfaction any questions or concerns.
- I understand that medical, nursing, sleep technician and/or 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 a healthcare worker is exposed to my blood or body fluid in a way which may transit HIV (Human Immuno-deficiency 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 state law.
- **Covid-19 Request:** Should I, the patient being provide diagnostic sleep services, receive a positive Covid-19 test result within a two-week period from my sleep testing; I will notify At Home Sleep Studies so they may take proper precautions.
- 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 and records retention according to Federal/State law.
- **DISCLOSURE:** Home Sleep Testing is unsupervised therefore validity of patient's testing cannot be certified. I, the undersigned, attest the Home Sleep Test was performed on myself and represents my own personal sleep.
- **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 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 Notice of Privacy Practices.

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

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

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

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 Studies.***

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. Chest and Abdominal Blue Belts or Home Sleep Testing Black Belt are disinfected and sanitized with Madacide-FD or Control III which may cause skin irritation or rash. We recommend wearing a loose-fitting article of clothing such as a T-Shirt under the belt to avoid any concerns.
5. 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.
6. 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.
7. 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.
8. I will be free to roll over and move in bed during In-Lab or Home diagnostic sleep study.
9. I will ask for help if I need to get out of bed for any reason during my In-Facility diagnostic sleep test.
10. Technician may need to enter the room to wake me for technical reasons during my In-Facility diagnostic sleep test.
11. 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.
12. I understand why I am taking and having a diagnostic sleep study.
13. 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 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

At Home Sleep Studies

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

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

"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 Obstructed Sleep Apnea (OSA)
- Approximately 42 million American adults have Sleep Disorder Breathing (SDB)
- Approximately 1 in 5 adults has mild OSA
- Approximately 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
- 5.1 million people in the US have heart failure
- Approximately 76% of CHF patients have SDB
- Arrhythmias noted in 50–75% of OSA patients
- 49% of atrial fibrillation patients have OSA
- 70% of heart attack patients have OSA with AHI > 5
- 52% of heart attack patients with AHI > 10

Hypertension Links
- Sleep apnea is an independent risk factor for hypertension
- 30–83% of patients with hypertension have sleep apnea
- 43% of patients with mild OSA have hypertension
- 69% of patients with severe OSA have hypertension

Links to Type II Diabetes
- 48% of type II 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
- 86% of obese type II diabetic patients have sleep apnea

Stroke Risk
- 65% of stroke patients have SDB
- Up to 70% of patients in rehabilitation therapy following stroke have significant SDB (AHI > 10)
- Moderate to Severe sleep apnea triples stroke risk in men

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
- Severe sleep apnea raises death risk by 46%

Health Care Costs
(Economic consequences of untreated SDB)
- Patients with untreated OSA had 82% higher In-Patient hospital costs than treated patients with PAP Therapy
- 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
- OSA patients on PAP Therapy have 31% lower medical costs

Traffic Accidents
- 15-fold increase of being involved in traffic accident
- In 2000; 810,000 US drivers were in motor vehicle accident related to OSA – 1,400 involved fatalities
- 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

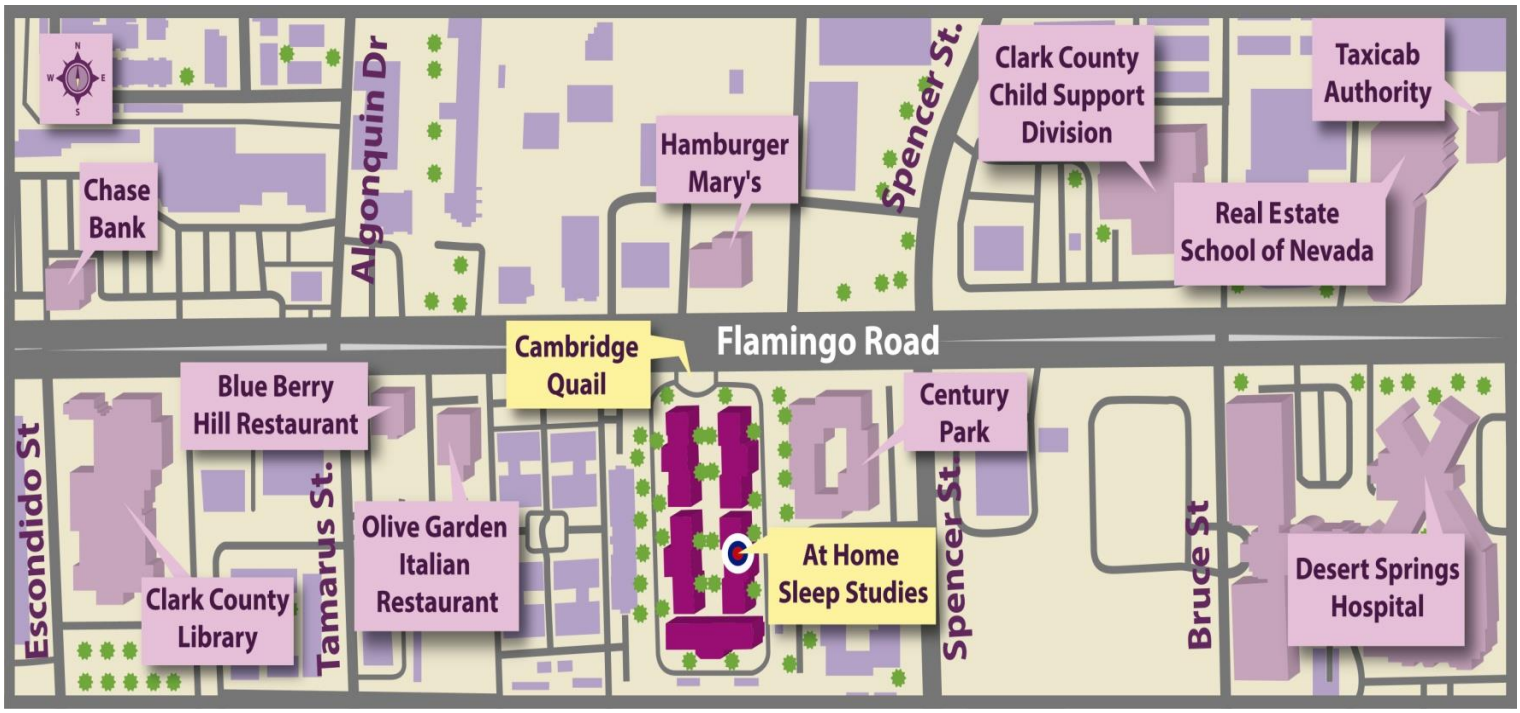
At Home Sleep Studies

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 **Cambridge Quail Property** (Blue & White Sign) between Spencer and Maryland Parkway.

PLEASE USE SUITE 4-A DOOR FOR ENTRANCE

This is a one story red brick building. Our suite is located on the east-side of the complex about halfway down.

HOURS OF OPERATION

- **Monday through Friday 9 am to 5 pm**
- **Overnight Diagnostic Sleep Testing Sunday – Saturday 7:30 pm to 5 am**
  By Appointment Only

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:_____

If You Currently Use CPAP Or BiPAP Therapy Answer Below Questions As If You Were Not Using Your Machine

PEDIATRIC 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 or Playing Video Games	_____
Sitting Inactive In A Public Place (Classroom At School / Movie Theater)	_____
As A Passenger In A Car Or Bus For An Hour Without A Break	_____
Lying Down To Rest Or Nap In The Afternoon When Circumstances Permit	_____
Sitting And Talking To Someone	_____
Sitting Quietly After Eating Lunch	_____
Doing Homework Or Taking A Test	_____
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:_____

GENERAL SLEEP	YES	NO
Does the child have a regular bedtime routine?	❑	❑
Does the child have his/her own bedroom?	❑	❑
Does the child have his/her own bed?	❑	❑
Is the parent present when your child falls asleep?	❑	❑

Child is usually put to bed by: ❑ Mother ❑ Father ❑ Both Parents ❑ Self ❑ Others:_____

Write in the amount of time the child spends in his/her bedroom before going to sleep: _____ minutes.

Child Usually Falls Asleep In	Child Sleeps Most Of The Night In	Child Usually Wakes In The Morning In
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parents' bed	☐ parents' room in parents' bed	☐ parents' room in parents' bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child resists going to bed? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO
Child has difficulty falling asleep? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO
Child awakens during the night? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO
After awakening has difficulty falling back to sleep? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO
Is difficult to awaken in the Morning? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO
Child is a poor sleeper? ❑ YES ❑ NO **IF YES**, do you think this is a problem? ❑ YES ❑ NO

Your child's usual bedtime on weekday nights: _____:_____ ☐ **a.m.** ☐ **p.m.**

The child's usual waketime on weekday mornings: _____:_____ ☐ **a.m.** ☐ **p.m.**

CURRENT SLEEP SYMPTOMS

0 = Never
1 = Not Often (less than 1 night/day a week)
2 = Sometimes (1 to 2 nights/days a week)
3 = Often (3 to 5 nights/days a week)
4 = Always (6 to 7 nights/days a week)

Bedwetting / Urinary Incontinence _____
Creepy-Crawly Feeling _____
Daytime Sleepiness _____
Difficulty Breathing When Asleep _____
Gets Out Of Bed At Night _____
Grinds His/Her Teeth _____
Kicks Legs In Sleep _____
Nightmares _____
Poor Appetite _____
Resists Going To Bed At Bedtime _____
Restless Sleep _____
Screaming In His/Her Sleep _____
Sleep Talking _____
Sleepwalking _____
Snores _____
Stops Breathing During Sleep _____
Sweating While Sleeping _____
Trouble Staying In His/Her Bed _____
Wakes Up At Night _____

CURRENT DAYTIME SYMPTOMS

0 = Never
1 = Not Often (less than 1 night/day a week)
2 = Sometimes (1 to 2 nights/days a week)
3 = Often (3 to 5 nights/days a week)
4 = Always (6 to 7 nights/days a week)

Daytime Sleepiness _____
Falls Asleep In School _____
Feels Weak Or Loses Control Of His/Her Muscles With Strong Emotions _____
Naps After School _____
Reports Unable To Move When Falling Asleep Or Upon Waking _____
Sees Frightening Visual Images Before Falling Asleep Or Upon Waking _____
Trouble Getting Up In The Morning _____

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

NAP SCHEDULE

Number of days each week child takes a nap: ☐ **0** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5 PLUS**

If child naps, write in usual nap time(s): Nap1: _____:_____ ☐ **a.m.** ☐ **p.m.** to _____:_____ ☐ **a.m.** ☐ **p.m.**

Nap2: _____:_____ ☐ **a.m.** ☐ **p.m.** to _____:_____ ☐ **a.m.** ☐ **p.m.**

PREGNANCY/DELIVERY

Pregnancy: ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-term ☐ Post-term

Child's birthweight: _____

Only child? ❑ YES ❑ NO **IF NO**, circle birth order: 1st 2nd 3rd 4th 5th 6th 7th

PAST MEDICAL HISTORY

Acid reflux (gastroesophageal reflux)	❑ YES	**IF YES**, Age of diagnosis:_____
Allergies	❑ YES	**IF YES**, Age of diagnosis:_____ Allergic to what:
Asthma	❑ YES	**IF YES**, Age of diagnosis:_____
Cerebral palsy	❑ YES	**IF YES**, Age of diagnosis:_____
Chromosome problem (e.g., Down syndrome)	❑ YES	**IF YES**, Age of diagnosis:_____
Chronic bronchitis or cough	❑ YES	**IF YES**, Age of diagnosis:_____
Craniofacial disorder (e.g., Pierre-Robin)	❑ YES	**IF YES**, Age of diagnosis:_____
Difficulty swallowing	❑ YES	**IF YES**, Age of diagnosis:_____
Eczema (itchy skin)	❑ YES	**IF YES**, Age of diagnosis:_____
Enlarged Tonsils / Tonsillitis	❑ YES	**IF YES**, Age of diagnosis:_____
Excessive weight	❑ YES	**IF YES**, Age of diagnosis:_____
Frequent cold or flu	❑ YES	**IF YES**, Age of diagnosis:_____
Frequent ear infections	❑ YES	**IF YES**, Age of diagnosis:_____
Frequent nasal congestion	❑ YES	**IF YES**, Age of diagnosis:_____
Frequent strep throat infections	❑ YES	**IF YES**, Age of diagnosis:_____
Genetic disease	❑ YES	**IF YES**, Age of diagnosis:_____
Hearing problems / Speech problems	❑ YES	**IF YES**, Age of diagnosis:_____
Heart disease	❑ YES	**IF YES**, Age of diagnosis:_____
High blood pressure	❑ YES	**IF YES**, Age of diagnosis:_____
Morning headaches	❑ YES	**IF YES**, Age of diagnosis:_____
Pain	❑ YES	**IF YES**, Age of diagnosis:_____
Poor or delayed growth	❑ YES	**IF YES**, Age of diagnosis:_____
Seizures/Epilepsy	❑ YES	**IF YES**, Age of diagnosis:_____
Sickle cell disease	❑ YES	**IF YES**, Age of diagnosis:_____
Sinus problems	❑ YES	**IF YES**, Age of diagnosis:_____
Skeletal issues (e.g., dwarfism)	❑ YES	**IF YES**, Age of diagnosis:_____
Thyroid problems	❑ YES	**IF YES**, Age of diagnosis:_____
Trouble breathing through his/her nose	❑ YES	**IF YES**, Age of diagnosis:_____
Vision problems	❑ YES	**IF YES**, Age of diagnosis:_____

SURGERIES/HOSPITALIZATIONS

Has your child ever had his/her tonsils removed?	❑ YES	**IF YES**, Age of surgery:_____
Has your child ever had his/her adenoids removed?	❑ YES	**IF YES**, Age of surgery:_____
Has your child ever had ear tube surgery?	❑ YES	**IF YES**, Age of surgery:_____

Please list any additional hospitalizations or surgeries: _____

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Anxiety/Panic Attacks	❑ YES	**IF YES**, Age of diagnosis:_____
Autism	❑ YES	**IF YES**, Age of diagnosis:_____
Behavioral Disorder & Type:_____	❑ YES	**IF YES**, Age of diagnosis:_____
Depression	❑ YES	**IF YES**, Age of diagnosis:_____
Developmental Delay	❑ YES	**IF YES**, Age of diagnosis:_____
Drug Use/Abuse	❑ YES	**IF YES**, Age of diagnosis:_____
Hyperactivity/ADHD	❑ YES	**IF YES**, Age of diagnosis:_____
Learning Disability & Type:_____	❑ YES	**IF YES**, Age of diagnosis:_____
Obsessive Compulsive Disorder	❑ YES	**IF YES**, Age of diagnosis:_____
Psychiatric Admission	❑ YES	**IF YES**, Age of diagnosis:_____
Suicidal Thoughts / Concerns	❑ YES	**IF YES**, Age of diagnosis:_____

CURRENT MEDICAL HISTORY

Please list the name and dose (in mg) of all medications your child currently takes **now** or **within the past 30 days**:

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

MY CHILD'S 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 HABITS

Does your child drink caffeinated beverages? ❑ YES ❑ NO **IF YES**, amount per day:_____
(e.g., Coke, Pepsi, Mountain Dew, iced tea)

SCHOOL PERFORMANCE (if school-aged)

Your child's grade: _____
Has your child ever repeated a grade? ❑ YES ❑ NO
Is your child enrolled in any special education class? ❑ YES ❑ NO
How many school days has your child missed so far this year?_____
How many school days did your child miss last year? _____
How many school days has your child missed this year?_____
How many school days has your child missed last year?_____
Child's grades this year: □ Excellent □ Good □ Average □ Poor □ Failing
Child's grades last year: □ Excellent □ Good □ Average □ Poor □ Failing

Have you received any comments from your child's school teacher(s) regarding excessive daytime sleepiness or behavioral concerns while at school? ❑ YES ❑ NO Please Explain:_____

LONG-TERM MEDICAL PROBLEMS If your child has long-term medical problems, please list the three you think are most important.

_____