THIS IS AN ONLINE FILLABLE FORM.

IMPORTANT

1) BEFORE YOU BEGIN, YOU MUST FIRST SAVE THIS FORM TO YOUR COMPUTER.
2) NEXT, OPEN YOUR SAVED FILE AND ENTER YOUR INFORMATION;
3) SAVE YOUR DOCUMENT TO YOUR COMPUTER
4) OPEN YOUR EMAIL, ATTACH THE FILE THAT HAS YOUR COMPLETED FORM AND SEND IT TO:

tmorris@costrinisleep.com

danderson@costrinisleep.com

Completing this paperwork in advance of your appointment helps with patient flow and minimizes patient wait times.

Thank you for taking the time to complete these required forms.

COSTRINI SLEEP SERVICES, INC.

11909 McAuley Drive,
Plaza C, Suite A-1
Savannah, GA 31419
(912) 927-6680 phone, (912) 927-0062 fax

Good Sleep, Inc.
COSTRINI SLEEP SERVICES
Buono Sonno, Buona Vita
Good Sleep, Good Life

Welcome to Costrini Sleep Services

We would like to thank you for choosing us as your sleep health care provider. Your health is a responsibility we take very seriously. Costrini Sleep Services specializes in providing diagnosis, treatment, and medical management for individuals with sleep / wake disorders such as sleep apnea, insomnia, narcolepsy, and others.

Our office is located at 11909 McAuley Drive, Plaza C, Suite A-1 in Savannah. Please see driving directions.

Hours of Operation: 9:00 until 5:00 on Monday – Thursday and 9:00 until 12:00 noon on Fridays

Appointment: As a new patient, the appointment you are scheduled for is a consultation & evaluation with Dr. Anthony Costrini. It is not for a sleep study. If we determine that a sleep study is necessary, we will schedule you at a time convenient for you.

Enclosed are several forms and questionnaires. It is important that you complete and bring these with you to your first appointment. These will assist us in assessing whether or not you may have a sleep disorder. Completion of these forms will take about 20 minutes. **PLEASE COMPLETE THESE FORMS BEFORE ARRIVING FOR YOUR APPOINTMENT OR COME IN 20-25 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME** in order to complete these forms and questionnaires by the time of your scheduled appointment.

Please bring the following items:

- Current health insurance card or cards if you have coverage with 2 or more insurance companies
- Valid driver's license or other state or federally issued photoidentification
- Utility bill or other correspondence showing your current residential address – if your photo ID does not show your current address
- If you are currently using CPAP or BiPAP or have used it in the recent past, please bring your machine if you still have it

Co-Payment: your co-payment is required at the time of service. We accept cash, check, or credit card.

Missed Appointment: If you are unable to keep your appointment, please call at least 24 hours in advance to let us know. We will be happy to re-schedule you for a more convenient time. You will be billed a $35.00 missed appointment fee if you do not call us in advance to cancel or re-schedule.

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PATIENT INFORMATION

TODAY'S DATE: _____

Name	SS #	Driver's License #
Date of Birth	Age	E-mail Address
Address		
City	State	Zip Code
Home Phone	Cell Phone	Business Phone

Marital Status	❑ Single	❑ Married	❑ Divorced	❑ Widowed

Employer	
Position/Job Title	
Name of Spouse	Date of Birth
Employed By	SS #
Referring Physician	Primary Care Physician
Insurance Company	Policy #
Medicare #	Medicaid #

Person responsible for this account:

Name	Address	Relationship to Patient

Name, address, and phone of nearest relative not living at your address:

Name	Address	Phone

I authorize Anthony M. Costrini, MD to release to my insurance company any information required for services provided. I also assign any insurance benefits to Anthony M. Costrini, MD for any and all charges met by the insurance company.

I understand that I remain responsible to Anthony M. Costrini, MD for any and all charges not met by the insurance company.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of the collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I understand that if my office visit requires that I be seen by the nurse practitioner and/or the respiratory therapist that I will be billed for those services accordingly.

Signature:_____ Date: _____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical information about me to release such information to Anthony M. Costrini, MD as it applies to my care and treatment rendered by Anthony M. Costrini, MD.

Signature:_____ Date: _____

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SLEEP HEALTH QUESTIONNAIRE

NAME:_____AGE:_____DOB: _____

What is your main problem or concern: _____

_____

_____

How long has this problem bothered you: ❑1-3 months, ❑3-6 months, ❑6-12 months, ❑ more than 1 year, ❑ more than 2 years

How often does it occur: ❑ Every night, ❑ 1-2 nights/week, ❑ 3-5 nights/week, ❑ Other: _____

Check any of the following that apply: ❑ Difficulty falling asleep ❑ Waking up during the night
❑ Difficulty waking up in the morning ❑ Excessive sleepiness during the day

What is your usual bedtime _____ How long does it usually take to fall asleep _____(min.)

How long do you usually sleep_____(hrs.) How many times do you usually wake up _____

What time do you wake up _____ How long do you usually stay awake _____(min/hrs)

What time do you get out of bed _____

Do you (check all that apply):

❑ Sleep with someone else in your bed ❑ Sleep with someone else in your room ❑ Sleep with the television on

❑ Provide assistance to someone else at night

Have you been told that you stop breathing in your sleep: ❑ Yes, ❑ No

Do any of the following disturb your sleep: ❑ Heat ❑ Cold ❑ Noise ❑ Light ❑ Bed partner

Are your sleep habits on the weekends different from the rest of the week: ☐ Yes ☐ No. If yes, please explain:

_____

_____

Does your sleep problems:

-Interfere with work duties/responsibilities: ☐ Yes, ☐ No If yes, please describe: _____

-Interfere with your social activities: ☐ Yes, ☐ No If yes, please describe: _____

-Interfere with your sexual activities: ☐ Yes, ☐ No If yes, please describe: _____

Have you been treated for any sleep problem ☐ Yes, ☐ No If yes, please describe: _____

Do any family members have sleep problems: ☐ Yes, ☐ No If yes, please describe: _____

SLEEP HEALTH QUESTIONNAIRE – PAGE 2

Do you or do you have (check all that apply):

- ❑ Snore
- ❑ Irritability
- ❑ Dream
- ❑ Sleep walk
- ❑ Stop breathing in your sleep as witnessed by someone else
- ❑ Memory loss
- ❑ Depression
- ❑ Act out your dreams
- ❑ Talk in your sleep
- ❑ Morning headaches
- ❑ Poor concentration
- ❑ Poor judgment
- ❑ Eat in your sleep
- ❑ Awaken gasping or choking
- ❑ Frequent urination at night
- ❑ Kick your legs during sleep
- ❑ Excessive sleepiness during the day

Do you:

-Smoke ☐ Yes, ☐ No – If yes, How many packs per day _____

-Drink ☐ Yes, ☐ No – If yes, What and how much _____

-Take recreational drugs ☐ Yes, ☐ No – If yes, What and how often _____

Do you have or have you had (check all that apply):

- ❑ Headaches
- ❑ Seizures
- ❑ Lung disease
- ❑ Weight gain
- ❑ Anxiety or depression
- ☐ Head injury
- ❑ Stroke
- ❑ Diabetes
- ❑ Sinus disease
- ❑ Bipolar
- ❑ Coma
- ❑ High blood pressure
- ❑ Gastroesophageal reflux
- ❑ Allergies or congestion
- ❑ Liver disease
- ❑ Visual disturbance
- ❑ Heart disease
- ❑ Kidney disease
- ❑ Bladder disease
- ❑ Palate or sinus surgery

OPTIONAL: Please provide any additional information you would like Dr. Costrini to know about.

_____

_____

_____

_____

PLEASE COMPLETE ALL OF THE FOLLOWING SECTIONS. THANK YOU.

Have you ever had or been treated for (check all that apply):

- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Sleep apnea
- ☐ Cancer
- ☐ Chronic fatigue
- ☐ Depression
- ☐ Diabetes
- ☐ Head injury
- ☐ Facial injury
- ☐ Lupus
- ☐ Traumatic brain injury
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pleural effusion
- ☐ Pneumothorax
- ☐ Pulmonary embolism
- ☐ Pulmonary hypertension
- ☐ Atrial fibrillation
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ PTSD
- ☐ Stroke
- ☐ Eye problems
- ☐ Rhinitis
- ☐ Sinusitis
- ☐ Arthritis
- ☐ Cervical disc surgery
- ☐ Neuromuscular disorders
- ☐ Colitis
- ☐ Hepatitis/jaundice
- ☐ Reflux (gastro-esophageal)
- ☐ Anemia

Does or has anyone in your family had (check all that apply):

- ☐ Asthma
- ☐ COPD
- ☐ Diabetes
- ☐ Heart disease
- ☐ Lung disorder
- ☐ Narcolepsy
- ☐ Sleep Apnea
- ☐ Genetic disorder

Smoking Status

- ☐ Current smoker
  Packs/day_ How long ____
- ☐ Past smoker
  Packs/day_ How long When did you quit ____
- ☐ Other: _____

Drug Use – Recreational

- ☐ No
- ☐ Yes – please list:

_____
_____
_____
_____

Indicate who (on your mother's side of the family):

_____
_____
_____
_____
_____
_____
_____
_____

Alcohol Use

- ☐ Never use alcohol
- ☐ Occasional use:
  Type_____
  How much _____
  How often _____

Past Injuries

Type	Year

Indicate who (on your father's side of the family):

_____
_____
_____
_____
_____
_____
_____
_____

Recent hospitalizations

Reason	When

Surgery History

Type	Year

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EPWORTH QUESTIONNAIRE

EPWORTH SLEEPINESS SCALE

Patient:_____DOB:_____Date of Study: _____

Do you currently use CPAP or BiPAP – ☐YES ☐NO

What pressure are you on_____?

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 think about how they would affect you.

Use the following scale and choose the most appropriate number for each situation:

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

1. Sitting and reading……..	
2. Watching T.V……	
3. Sitting inactive in a public place (theater, meeting, etc.)……	
4. As a passenger in a car for an hour without a break……..	
5. Lying down to rest in the afternoon……	
6. Sitting and talking to someone……	
7. Sitting quietly after lunch without alcohol……..	
8. In a car, while stopped for a few minutes in traffic……..	
TOTAL SCORE……	

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FOSQ QUESTIONNAIRE

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FOSQ QUESTIONNAIRE

Patient_____Date of Birth_____Date of Survey _____

FOSQ is a "quality of life" questionnaire designed specifically for people with sleep disorders. The results allow health care professionals to see how therapy has improved the quality of your life. By completing the questionnaire periodically, you can provide valuable information about the effectiveness of your treatment.

In this questionnaire, when the words "sleepy" or "tired" are used, it describes the feeling that you can't keep your eyes open, your head is droopy, that you want to nod off or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised. Please answer the questions below using numbers 0 to 4. See the answer key below.

Answer Key		
0	=	I don't do this activity for other reasons
1	=	Yes, extreme
2	=	Yes, moderate
3	=	Yes, a little
4	=	No

Question		0	1	2	3	4
1.	Do you generally have difficulty concentrating on the things you do because you are sleepy or tired?					
2.	Do you generally have difficulty remembering things because you are sleepy or tired?					
3.	Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?					
4.	Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?					
5.	Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?					
6.	Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired?					
7.	Do you have difficulty watching a movie or videotape because you become sleepy or tired?					
8.	Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?					
9.	Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?					
10.	Has your desire for intimacy or sex been affected because you are sleepy or tired?					

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LIST OF CURRENT MEDICATIONS

NAME:_____TODAY'S DATE:_____AGE:_____DOB: _____

Please list all of your current medications, strength, dosage, and date prescribed in the table below. Thank you.

MEDICATION	STRENGTH	DOSE	DATE PRESCRIBED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

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INSURANCE AND FINANCIAL POLICY

Understanding your insurance coverage can be quite challenging. Each insurance plan is slightly different in its coverage of services. We encourage you to become familiar with your policy and its' exclusions, deductibles, required co-payments/co-insurance. You are responsible for all co-payment and unmet deductible amounts.

We will bill your insurance company for office visit appointments with your physician. However, your co-payment for the office visit is required at the time of service. If you have an unmet deductible, your insurance company may apply their allowed office visit charge towards your deductible. If this occurs, we will bill you for this amount.

Freedom of Choice – CPAP / BiPAP equipment is also available through other medical equipment suppliers. You may choose to purchase your equipment from another provider. We want our patients to receive the very best medical care possible. You may wish to ask them about the education, follow-up, and other support services they provide.

Payment Methods – While there are differences between insurance companies and even between insurance plans within the same company, generally most companies reimburse for a CPAP machine in one of three ways: (1) monthly rental of the machine for 3 months followed by paying the balance of the purchase price, (2) monthly rental for 10-12 months after which the machine is considered purchased, or (3) full purchase of the machine during the first month. Supplies such as the humidifier, mask, tubing, and filters are always purchased during the first month. With any of these methods, the insurance company will reimburse us for their portion of the charges. You are responsible for the co-pay portion of the charges. We will bill you on a monthly basis.

Insurance Deductible – If all or any portion of your insurance deductible has not been met at the time of service, you are responsible for the allowed amount, as determined by your insurance company, at the time of service. Payment of this amount is due in full at or before the time of service. When we bill your insurance company, they will apply the amount you paid towards your unmet deductible.

Missed Appointment Fee – Please give us at least 24 hours notice when you need to cancel or re-schedule an appointment for an office visit or a sleep study [phone (912) 927-6680 during office hours or (912) 927-5672 to reach the Sleep Tech if after hours]. We do charge a fee for missed appointments without notice, billed directly to you. Insurance companies do not cover missed appointment fees.

The missed appointment fees are: $35.00 for an office visit and $150.00 for a sleep study.

Financial Responsibility – By signing below I am indicating that I understand the above insurance and financial policy information and agree to be personally responsible for my co-insurance and any portion of my deductible that has not been met at the time of service for physician office visits and sleep studies. I also understand and agree that I am fully responsible for any charges that my insurance company does not pay or pays me and should have paid Costrini Sleep Services. If, for any reason, I default on incurred charges, I will be responsible for any reasonable attorney or collection fees incurred in the collection of these charges.

I have read and understand the above financial policy:

_____ /_____

Signature of Patient/Responsible Party Date

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HOW TO FIND OUR OFFICE & SLEEP CENTER

Our office and Sleep Center are located at 11909 McAuley Drive, Suite A-1, in Plaza C of the St. Joseph's Medical Office Park, across the street from St. Joseph's Hospital on Mercy Blvd. Turn-by-turn directions are available on our website at www.costrinisleep.com and can be viewed on your computer or Smartphone.

From Oglethorpe Mall (headed south on Abercorn Street towards I-95):
Turn right onto Mercy Blvd. and go past the hospital (about 3 blocks). Turn right into Plaza C onto McAuley Drive. The office will be on the left side of the road just as the road starts to curve.

From Savannah on Hwy 204 (headed north on Abercorn Street):
Turn left onto Mercy Blvd. and go past the hospital (about 3 blocks). Turn right into Plaza C onto McAuley Drive. The office will be on the left side of the road just as the road starts to curve.

If you need additional assistance in finding our office, please call us at (912) 927-6680. If you are scheduled for a sleep study and need to reach the sleep tech after 8:00 PM, please call (912) 927-5672.

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PATIENT RIGHTS & RESPONSIBILITIES

As a patient of Costrini Sleep Services, you have the right to:

1. To be treated with dignity and to have your privacy respected at all times.
2. To exercise your rights as a client or to have your authorized, designated representative exercise your rights as a client.
3. To select those who provide you with home medical equipment and to receive services promptly and professionally.
4. To receive appropriate care and services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference, physical or mental handicap, or personal cultural and ethnic preferences and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by agency staff.
5. To be informed verbally and in writing of billing and reimbursement methodologies prior to the start of care and as changes occur, including fees for services and products provided, direct pay responsibilities, and notification of insurance coverage.
6. To participate in the development and modification of your care and service plan; to refuse treatment, within the boundaries set by law.
7. To review the Costrini Sleep Service's Privacy Practices Notice.
8. To express concerns or grievances or recommend modification to your services without fear of discrimination or reprisal and to be involved, as appropriate, in discussions and resolutions of conflicts and/or ethical issues related to your care.
9. To be provided with legitimate identification by any person or persons who provides care or services toyou.
10. To receive disclosure information regarding any beneficial relationships Costrini Sleep Services has that may result in profit for the referring organization.
11. To not receive any experimental treatment without your specific agreement and full understanding of information explained.
12. To be fully informed of your rights and responsibilities.

And you have the responsibility:

13. To provide complete and accurate information concerning your present health, medication, allergies, etc. when appropriate to your care/service.
14. To involve yourself, as needed and as able, in developing, carrying out, and modifying your care plan.
15. To review Costrini Sleep Services safety materials and actively participate in maintaining a safe environment in your home.
16. To request additional assistance or information on any phase of your health care plan you do not fully understand.
17. To notify your attending physician when you feel ill, or encounter any unusual physical or mental stress or sensations.
18. To notify Costrini Sleep Services when you will not be able to come to a scheduled appointment.
19. To notify Costrini Sleep Services prior to changing your place of residence or telephone number.
20. To notify Costrini Sleep Services when encountering any problem with your equipment orservice.
21. To notify Costrini Sleep Services if you are to be hospitalized or if your physician modifies or discontinues your prescription for durable medical equipment.

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In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner:

□ ***Home Phone*** – it is ok to leave a message with detailed information

□ ***Cell Phone*** – it is ok to leave a message with detailed information

□ ***Work Phone*** – it is ok to leave a message with detailed information

□ ***Written Communication*** – it is ok to mail to my home address

□ ***Fax Communication*** – it is ok to fax to this telephone number: _____

□ ***Email*** – it is ok to email this address with detailed information: _____

You may leave a message with, discuss my treatment, appointments, financial obligations, or other scheduling that may occur or give other information as necessary with the following family, friends, or personal representatives. I understand that Costrini Sleep Services will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand this consent does not apply to medical providers.

Please Print:

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient/Guardian Signature Date

_____ _____
Please Print Patient's Name Patient's Date of Birth

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PRIVACY PRACTICES NOTICE

Patient Acknowledgment of Receipt of Privacy Practices Notice

I,_____, hereby acknowledge that I have reviewed and received a copy of Costrini Sleep Service's "Notice of Privacy Practices" explaining:

- How Costrini Sleep Services will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- Costrini Sleep Service's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Costrini Sleep Services, Inc.
11909 McAuley Drive
Plaza C, Suite A-1
Savannah, GA 31419

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

PATIENT OR PERSONAL REPRESENTATIVE

Signature:_____Date: _____

Name:_____

Relationship to Patient:_____

For Costrini Sleep Service's Use Only

We made a good faith effort to obtain an acknowledgment from_____for receipt of our Notice of Privacy Practices. In spite of these efforts, we have been unable to obtain a signed acknowledgment of receipt due to the following reasons:

❑ Patient refused to sign (date of refusal)_____/_____/_____.
❑ Communication barriers prohibited obtaining an acknowledgment.
❑ An emergency situation prevented us from obtaining an acknowledgment.
❑ Other:_____

Attempt was made by:_____Date: _____