



# 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



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*"Everyone Deserves Restful Sleep"*

## **What To Expect And How To Prepare For Your Sleep Study**

### **What Is A Sleep Study?**

For most patients, a sleep study is a key diagnostic component of a sleep disorder evaluation. A sleep study, also called a polysomnogram (PSG), measures brain wave activity, eye movements, muscle contractions, heart activity, breathing and blood oxygenation during sleep. The information we collect during your sleep study is reviewed and analyzed by our ABIM Board Certified Sleep Physician.

### **What Information Will I Get Before The Study?**

Once you have scheduled the sleep study, you will receive a new patient packet by email containing forms to be completed, along with directions and phone numbers to the facility. **Be Sure To Bring Completed Forms, Your ID, Your Health Insurance Card & Any Out-Of-Pocket Cost On The Night Of Your Sleep Study.**

### **Will Someone Call To Remind Me Of My Scheduled Appointment?**

You will be reminded 1-week before by text and email and the day of your scheduled sleep appointment. Please let us know if there are any changes in your health, if you feel ill or if you had any recent medical treatments that may require rescheduling of your sleep study. **We Must Conduct An Over-The-Phone Health & Wellness Check On Day Of Your Scheduled Appointment. If We Do Not Speak With You, Your Appointment May Be Subject To Cancellation.**

### **Will I Have A Private Bedroom?**

Yes, all of our bedrooms are private and some rooms are set up with sleep accommodations for an additional person. Should you require an additional person to stay overnight with you, please notify us so we can reserve the appropriate bedroom for your sleep study.

### **What Should I Pack In My Overnight Bag?**

- Comfortable sleepwear: two-piece pajamas or shorts and a T-Shirt. **No sleep clothing with metal or zippers.**
- Bring any medications you usually take at night or early in the morning.
- Bring any medications you don't take on a regular basis, but may need in an urgent situation, for example an **Inhaler**, **Anti-Seizure Medicine** or an **EpiPen**.
- Incontinence concerns both urinary and fecal please bring and utilize adult incontinence diaper or underwear. This will help protect from damaging bed, sensors, wires or medical equipment.
- Extra set of pajamas or shorts and a T-Shirt, in case of accident.
- Clothing for the next day.
- Speak with your medical provider and request a 1-night sleep aid. The sleep aid may or may not be necessary but if it is, you will be glad you have it.

### **What If I Have Special Needs?**

Call our scheduling office at 702-463-8062 between 9 AM and 5 PM, Monday through Friday. We will try to accommodate your needs and answer any questions you may have about the sleep study procedure.

### Should I Eat Dinner Before The Study?

Make sure to eat a light dinner at least 1-Hour before arriving to the Sleep Center. There will not be time to eat once you are here because the sleep technicians will need all of the scheduled time to prepare you for your sleep study.

### Should I Bring Snacks?

Plan on bringing any special snacks you may need before bedtime and/or breakfast in the morning – remembering that **No Caffeine Products Such As Coffee, Tea, Cola Drinks Or Chocolate Are Allowed.**

### What About Medications?

Please take your medications as usual and bring them to the sleep center, if necessary. **Our Staff Or Sleep Technologist Will Not Be Able To Administer Or Dispense Any Medication To You.** We also recommend that you discuss with your medical provider whether the medications will affect the sleep study results. **It Is Extremely Important That You Bring Any Medications You Don't Take On A Regular Basis, But May Need In An Urgent Situation, For Example An Inhaler, Anti-Seizure Medicine Or An EpiPen.**

### What About Sleep Aid?

Conducting sleep testing in a strange environment can be difficult and we need your help. You may have increased anxiety causing you not to sleep. This can result in your test not being completed and a delay of your care. **It May Be Beneficial To Speak With Your Medical Provider And Request A 1-Night Sleep Aid.** The sleep aid may or may not be necessary but if it is, you will be glad you have it.

### On The Day Of Your Sleep Study?

Wake up early and stay awake and active (*avoid napping, if able*) to maximize sleep during your sleep study. It is very important that you avoid drinking or eating any caffeine or sugary foods or drinks (**Chocolates, Coffee, Colas, Energy Drinks, Tea, Etc.**) on the day of your sleep study.

### What About Daytime Naps?

It is helpful if you are able to not sleep all day or limit naps to help facilitate your sleep during the sleep study. **It May Be Beneficial To Speak With Your Medical Provider And Request A 1-Night Sleep Aid.**

### What Time Should We Arrive?

You should arrive as close as possible to your **Scheduled Appointment Time**. Sleep staff is scheduled to arrive 5 minutes prior to the first appointment which is 7:30 PM. If you are scheduled at 7:30 PM and you arrive earlier than your scheduled time, the sleep center may not be staffed or open yet.

### What Should I Do To Get Ready The Day Of The Study?

- **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 clean and 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. **Deodorant is OK to use on underarms.**
- **DO:** - remove braids, hair weaves, and hair accessories (Clips, Rubber Bands, etc.).
- **DO NOT** schedule a hair appointment for Sew-In Weaves, Glue-In Weaves or braids before your scheduled sleep appointment. ***They Interfere With Placement Of Paste And Head Sensors On Scalp Of Your Head.***
- **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!
- **DO:** - bring 1-Night Sleep Aid. The sleep aid may or may not be necessary but if it is, you will be glad you have it.

### **What Happens When We Arrive At The Sleep Center?**

The first scheduled sleep study usually begins at 7:30 PM in the evening and all sleep studies are finished between 4 AM to 5 AM. Once you arrive at the sleep center, a sleep technologist will welcome you and show you to a private bedroom. The sleep technologist will collect completed forms, your ID, your health insurance card and collect any payment if necessary. The sleep technologist may have some additional forms to be filled out and answer any questions.

### **How Will I Get Ready For The Study?**

The sleep technologist will place a number of non-painful sensors (called electrodes) on your head, chest area and legs. The areas where the sensors will be attached are cleaned and the electrodes are attached with special gels and paste. (The gels and paste are harmless; however, if you have sensitive skin, please alert the sleep technologist prior to attaching the electrodes.) Elastic belts with sensors will be placed around your chest and abdomen. Airflow sensors will be placed under your nose and a finger clip will be applied to monitor oxygen levels. All sensors are connected to a small portable box that transmits signals to the sleep monitoring and recording equipment.

### **Will I Be Able To Sleep With So Many Things Attached?**

You may find it a bit strange at first, but most patients do not find it uncomfortable or an obstacle to fall asleep. We will make every effort to ensure that you are as comfortable as possible.

### **What Do We Do While Waiting To Fall Asleep Or During Any Free Time?**

**Because We Are Gathering Brain And Heart Waves, We Do Not Have Wi-Fi And Do Not Allow Computer Or Phone Usage While Testing Is In Progress. These Devices May Interfere With Your Actual Body Signals.** You may watch TV in your room or bring reading materials.

### **What Happens While I Am Sleeping?**

The sleep lab is a busy place and there will be other patients being monitored during the same evening. The sleep technologists remains awake in the technician station throughout the night analyzing the information being collected while you sleep. You can communicate with the technologist at any time.

### **What If I Need To Go To The Bathroom At Night?**

If you need to use the bathroom during the night, you can notify your sleep technologist for assistance. They will temporarily disconnect you from the sleep monitoring equipment.

### **When Is The Study Over?**

The sleep study is completed between 4:00 AM to 4:30 AM in the morning. It will take your sleep technologist approximately 30 minutes to remove the electrodes and sensors. If you have long or thick hair, it may take longer. **You And Will Be Ready To Leave Between 4 AM To 5 AM.**

### **What Happens After The Sleep Study?**

A large amount of information is collected during your sleep study (720 – 800 pages of data). Our Board-certified sleep physician will analyze this information and create a sleep report with recommendations that will be sent to your ordering medical provider. On the morning of the study, **The Sleep Technologists Cannot Provide You With Any Information About Your Sleep Testing Results.**

### **When Will My Doctor Receive My Sleep Results?**

It may take up to two weeks for your doctor to receive the sleep results report. Please schedule a follow-up visit with your doctor after that time to discuss the findings and recommendations for treatment.

**YOU HAVE NOW BEEN SCHEDULED FOR YOUR SLEEP STUDY. PLEASE BE AWARE APPOINTMENTS ARE EXTREMELY LIMITED & IN HIGH DEMAND. THEREFORE, IF YOU FAIL TO NOTIFY US WITHIN 48 HOURS OR FAIL TO SHOW FOR YOUR SCHEDULED SLEEP APPOINTMENT, WE MAY NOT BE ABLE TO RESCHEDULE YOUR SLEEP TESTING.**

If you have any questions, please call or text us at (702) 463-8062. Thank you for allowing us the opportunity to participate in your sleep care. Our diagnostic technician will provide you with the highest level of personal, professional and quality care. We hope your overnight stay at our facility will be a comfortable and pleasant experience.

## 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](http://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 DISCLOSE 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@gmail.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 transmit 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 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



**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**

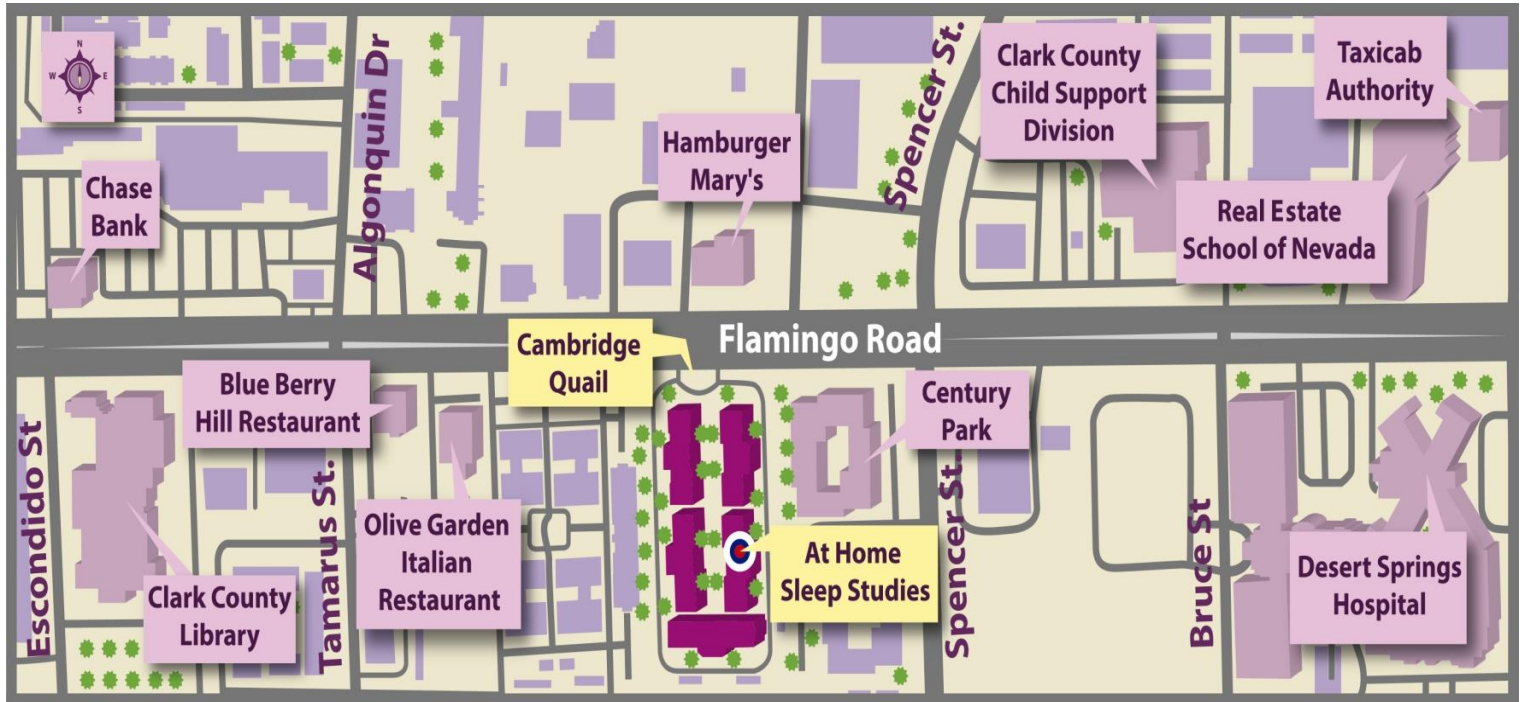
- 15-fold increase of being involved in traffic accident
- In 2000; 810,000 US drivers were in motor vehicle accident related to OSA – 1,400 involved fatalities
- Treating all US drivers suffering from sleep apnea would save \$11.1 billion in collision costs & 980 lives annually

### **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



**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



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

## 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 or have pauses in breathing during sleep
- ☐ I wake up at night choking, smothering or gasping for air
- ☐ I have been told that I have loud or disruptive snoring
- ☐ 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**

Have you **EVER** smoked Cigarettes, Cigars, Pipe and/or Vape on a daily basis? ☐ Yes ☐ No

When you were smoking your heaviest, how many of each did you smoke on an average day?

- |   |  |
|---|--|
| <input type="checkbox"/> Cigarettes _____ pack(s) _____ years | <input type="checkbox"/> Cigars _____ Cigars _____ years |
| <input type="checkbox"/> Vape _____ MG _____ years            | <input type="checkbox"/> Tobacco _____ Pipes _____ years |

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

- |   |
|---|
| <input type="checkbox"/> Beer <input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare _____ cans/week    |
| <input type="checkbox"/> Wine <input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> Rare _____ glasses/week |
| <input type="checkbox"/> Liquor <input type="checkbox"/> Daily <input type="checkbox"/> Weekends <input type="checkbox"/> 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 currently use home Oxygen. Your Oxygen Setting/LPM: \_\_\_\_\_ Oxygen Prescribed ☐ 24/7 or ☐ During Sleep
- ☐ I currently use PAP equipment for home use ☐ CPAP ☐ BiPAP ☐ ASV Your Pressure Settings: \_\_\_\_\_
- Last time you used PAP Therapy: \_\_\_\_\_ Mask Type: ☐ Full face ☐ Nasal ☐ Pillow DME Provider: \_\_\_\_\_
- ☐ 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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abnormal Heart Rhythms        | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Muscle Cramps             |
| <input type="checkbox"/> Anxiety Disorders             | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Narcolepsy                |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Opioid Use                |
| <input type="checkbox"/> Atrial Fibrillation           | <input type="checkbox"/> Heartburn/GERD          | <input type="checkbox"/> PTSD                      |
| <input type="checkbox"/> Bipolar Disorder              | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Restless Leg Syndrome     |
| <input type="checkbox"/> Black-Outs                    | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Ringing of the Ears       |
| <input type="checkbox"/> Cancer ( <i>type</i> ): _____ | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Schizophrenia             |
| <input type="checkbox"/> Congestive Heart Failure      | <input type="checkbox"/> Impotence               | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> COPD                          | <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Shift Work Sleep Disorder |
| <input type="checkbox"/> Coronary Artery Disease       | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Sleep Paralysis           |
| <input type="checkbox"/> Depression                    | <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Stroke / TIA              |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Mental / Mood Disorders | <input type="checkbox"/> Tuberculosis              |
| <input type="checkbox"/> Frequent Urination            | <input type="checkbox"/> MRSA                    | <input type="checkbox"/> Other: _____              |

**SURGERIES AND HOSPITALIZATIONS**

Please list any hospitalizations and/or surgeries you have had in the last two years.

PLACE THE LATEST FIRST: Include Where, What, Why, and When.

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

**CHECK ONE BOX FOR EACH STATEMENT OF USAGE**

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>
A. Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Hallucinogens (LSD, Mescaline, Angel dust, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Stimulants (uppers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Depressants (downers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Narcotics (heroin, morphine, opium, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

<u>Medication</u>	<u>Dose</u>	<u>What for?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

<u>Name</u>	<u>Did it help?</u>
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

\_\_\_\_\_