



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 Child's 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 child's 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 Child's Health Insurance Card & Any Out-Of-Pocket Cost On The Night Of Your Child's Sleep Study.**

Will Someone Call To Remind Me Of The Appointment?

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

Will We Have A Private Bedroom?

Yes, all of our bedrooms are private and each room is set up with sleep accommodations for both you and your child. One parent/legal guardian is required to stay overnight in sleep facility with the child. **One Parent/Legal Guardian Must Stay With The Child At All Times Throughout The Study.**

What Should I Pack In My Child's Overnight Bag?

- Two-piece pajamas set (a top and bottom without zippers) or shorts and a t-shirt. **Please Do Not Bring One-Piece Or Footed Pajamas.**
- Any medications your child usually takes at night or early in the morning.
- Any medications your child doesn't take on a regular basis, but may need in an urgent situation, for example an inhaler, anti-seizure medicine or an EpiPen.
- Bring any blanket, stuffed animal, pillow or other special item that your child usually sleeps with, or something that will help your child feel "at home" in the sleep center.
- Bottle or sippy cup, if your child uses one.
- Diapers, training pants, pull-ups and wipes if your child is not fully potty-trained or has a history of bed-wetting.
- Extra set of pajamas, in case of accident.
- Clothing for the next day.
- If you usually read to your child at bedtime, please bring a book with you.

What If My Child Has 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 child's needs and answer any questions you may have about the sleep study procedure.

Should I Feed My Child Dinner Before The Study?

Make sure to eat dinner 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 your child for their sleep study.

Should I Bring Snacks For My Child?

Plan on bringing any special snacks your child 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 give your child their medications as usual and bring them to the center, if necessary. **Our Staff Or Sleep Technologist Will Not Be Able To Administer Or Dispense Any Medication To Your Child.** We also recommend that you discuss with your pediatrician whether the medications will affect the sleep study results. It is extremely important that you bring any medications your child doesn'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 on children can be difficult and we need your help. Children may have increased anxiety causing them to not sleep. This can result in your child's test not being completed and a delay of their care. **It May Be Beneficial To Speak With Your Child's 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 Child's Sleep Study?

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

What About Daytime Naps?

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

What Time Should We Arrive?

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

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

- Do not apply any hair spray, gels or oil to your child's hair – it will need to be clean and dry.
- Do not apply lotions or creams to your child's skin.
- Please remove braids, hair weaves, and hair accessories (Clips, Rubber Bands, etc.).
- Pack an overnight bag for yourself and your child.
- Arrive at the Sleep Center at your **Scheduled Appointment Time Of 7:30 PM.**
- Parents/caregivers should wear comfortable clothing.
- 1-Night Sleep Aid

What Happens When We Arrive At The Sleep Center?

The study usually begins at 7:30 in the evening and ends between 4 AM to 5 AM. Once you arrive at the center, a sleep technologist will welcome you and show you and your child to a private bedroom. The sleep technologist will collect completed forms, your ID, your child's 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 you may have.

How Will My Child Get Ready For The Study?

The sleep technologist will place a number of non-painful sensors (called electrodes) on their 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 your child has sensitive skin, please alert the sleep technologist prior to attaching the electrodes.) Elastic belts with sensors will be placed around your child's chest and abdomen. Airflow sensors will be placed under his/her 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 My Child Be Able To Sleep With So Many Things Attached?

Your child may find it a bit strange at first, but most children do not find it uncomfortable or an obstacle to fall asleep. We will make every effort to ensure that your child is as comfortable as possible. **Your Help Is Greatly Appreciated During Child Hook-Up & Going To Sleep. Remember To Bring 1-Night Sleep Aid If It Becomes Necessary.**

What Do We Do While Waiting For My Child To Fall Asleep Or During Any Free Time?

Please plan to spend the majority of your time with your child in his/her room. **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 Child's Actual Body Signals.** Watch TV in room or bring reading materials.

What Happens While We Are Sleeping?

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

What If My Child Needs To Go To The Bathroom At Night?

If your child needs to use the bathroom during the night, you can notify your sleep technologist for assistance. They will temporarily disconnect them 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 your child has long or thick hair, it may take longer. **You And Your Child 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 child's 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 child's prescribing physician. On the morning of the study, **The Sleep Technologists Cannot Provide You With Any Information About Your Child's Testing Results.**

When Will My Child's Doctor Receive The Results?

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

YOUR CHILD HAS NOW BEEN SCHEDULED FOR THEIR SLEEP STUDY. PLEASE BE AWARE PEDIATRIC APPOINTMENTS ARE EXTREMELY LIMITED & IN HIGH DEMAND. THEREFORE, IF YOU FAIL TO NOTIFY US WITHIN 48 HOURS OR FAIL TO SHOW FOR YOUR CHILD'S APPOINTMENT, WE WILL NOT BE ABLE TO RESCHEDULE YOUR CHILD'S SLEEP TEST.

If you have any questions, please call us at (702) 463-8062. Thank you for allowing us the opportunity to participate in your child's 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

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



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"Everyone Deserves Restful Sleep"

How Your Sleep Affects You

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

The Significant Health Consequences Of Sleep Disorders Have Led Experts To Agree That These Problems Warrant Medical Attention

Prevalence of 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

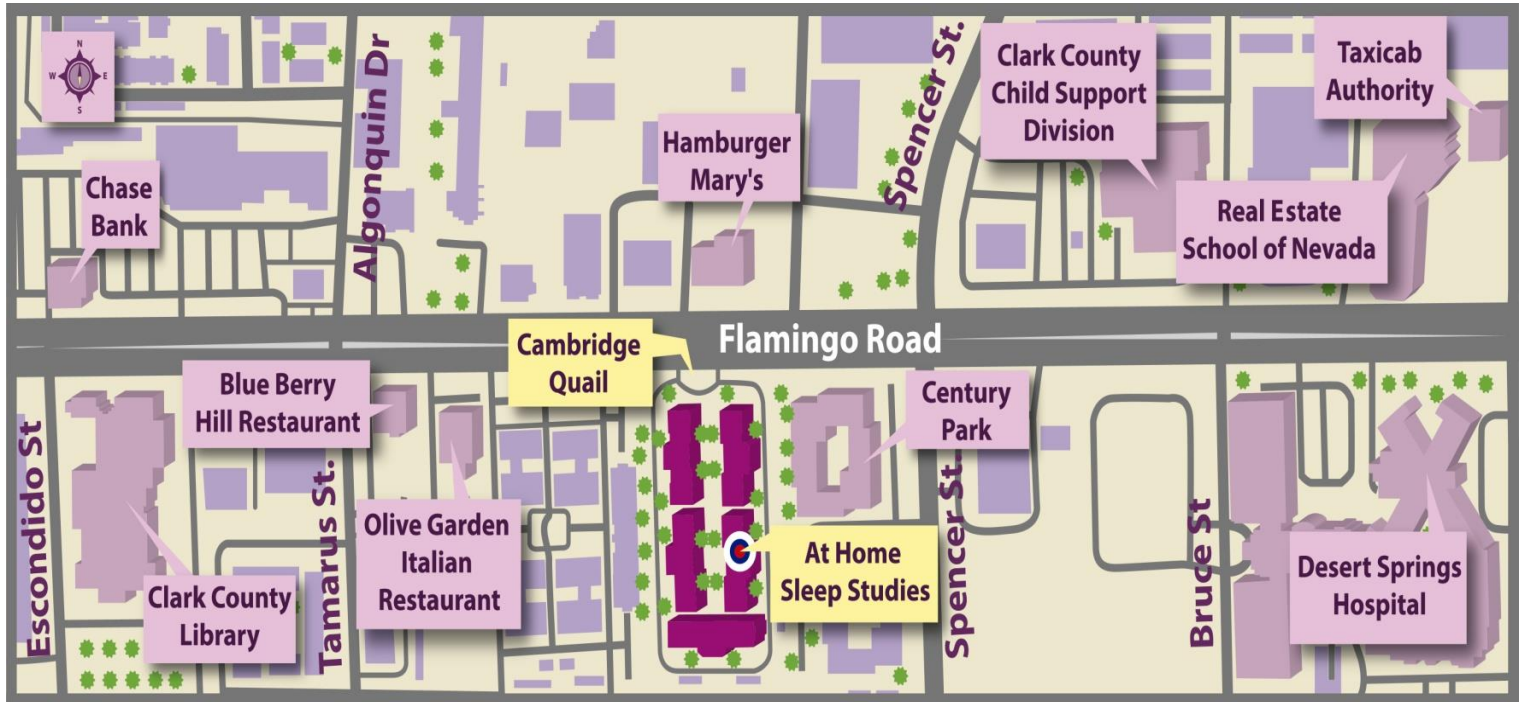
- 15-fold increase of being involved in traffic accident
- In 2000; 810,000 US drivers were in motor vehicle accident related to OSA – 1,400 involved fatalities
- Treating all US drivers suffering from sleep apnea would save \$11.1 billion in collision costs & 980 lives annually

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
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"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

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.

<u>Child Usually Falls Asleep In</u>	<u>Child Sleeps Most Of The Night In</u>	<u>Child Usually Wakes In The Morning In</u>
<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)	<input type="checkbox"/> own room in own bed (alone)
<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed	<input type="checkbox"/> parents' room in own bed
<input type="checkbox"/> parents' room in parents' bed	<input type="checkbox"/> parents' room in parents' bed	<input type="checkbox"/> parents' room in parents' bed
<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed	<input type="checkbox"/> sibling's room in own bed
<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> sibling's room in sibling's bed	<input type="checkbox"/> sibling's room in sibling's bed

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Child resists going to bed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child has difficulty falling asleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child awakens during the night?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
After awakening has difficulty falling back to sleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is difficult to awaken in the Morning?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Child is a poor sleeper?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, do you think this is a problem?	<input type="checkbox"/> YES <input type="checkbox"/> 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	_____

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

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PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

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

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

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.
