Epworth Scale

Patient Name_____ Date of Birth: _____

Males___/Female___ Height_____ Weight_____ Neck Size_____

Please list any medical problems (High blood pressure, Diabetes, Heart Disease, Epilepsy):

_____

1. Do you snore? Yes ☐ No ☐

2. Are you unable to stay awake in the daytime? Yes ☐ No ☐

3. Do you wake up with a headache in the morning? Yes ☐ No ☐

4. Do you wake up in the middle of the night unable to breath or gasping for air? Yes ☐ No ☐

5. Do you have sudden episodes of loss of muscle control, especially during emotional situations? Yes ☐ No ☐

6. Do your legs jerk at night or feel restless? Yes ☐ No ☐

7. Do you ever feel unable to move when falling asleep or waking up? Yes ☐ No ☐

8. Do you have problems falling asleep? Yes ☐ No ☐

9. Have you gained a lot of weight in a short time? Yes ☐ No ☐

10. Do you have a hard time falling asleep or staying asleep? Yes ☐ No ☐

11. Do you frequently awaken with (PLEASE CIRCLE)?
Dry Mouth Nasal Congestion Headache Heartburn Chest Pain
Choking and Gasping

ACCORDING TO THE FOLLOWING SCALE CHOOSE THE APPROPIATE NUMBER VALUE TO REPRESENT HOW LIKELY YOU ARE TO DOZE OFF OR FALL ASLEEP DURING THE DAY IN THE FOLLOWING SITUATIONS:

0- NEVER 1- SLIGHT CHANCE 2- MODERATE CHANCE 3- ALWAYS

Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (theatre, meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when possible	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

MEDICATION WORKSHEET

Please list any medications you are currently taking

	Type of Medication	**Dosage**	**Time of Dosage**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____

Please list any medications you have taken in the last two weeks

15.	_____	_____	_____
16.	_____	_____	_____
17.	_____	_____	_____
18.	_____	_____	_____
19.	_____	_____	_____

Patient Consent Form to Sleep Study Test

I authorize a_____ to be performed on _____
(List procedure) **(Print Name of Patient)**
Under the direction of **Dr.** _____.
(Name of Physician)

Home Sleep Testing (HST) or Polysomnography (sleep study) procedures are non-invasive multi channel recordings designed to record diagnostic physiologic parameters sleep disorders. Monitoring leads are attached with tape and medical crème. Minor skin irritation associated with the cleaning of the application sites and tape may be a side effect of the procedure.

When Continuous Positive Airway Pressure (CPAP), Bi-level pressure or oxygen is indicated by policy During a sleep study, it may be applied to improve cardiac or respiratory events occurring during sleep. Common complications of CPAP and Bi-level are dry mouth, burning sensation in the nose, skin irritation/infection and occasionally eye infection. With any procedure, there may be imponderable or unexpected side effects experienced. Notify the technologist of any discomfort you experience during your procedure.
Technologist Check Appropriate Choice:

Yes	No/Not applicable	
—	—	I consent to the recording of pictures with a camera, still or video, before or during the Procedure by the sleep technologist. All photographic documentation is kept confidential And to be used as part of a diagnostic procedure only (If applicable).

I certify that:

- I have read and have access to a copy of the Consent Form and the Patient Rights & Responsibilities form.
- I give permission to release any medical information in order to file any insurance claims and to any consulting physicians in regards to my medical history.
- I release Pro Sleep Care and its agents from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment.
- The nature and purpose of the procedure, the risks involved, and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be attained.
- I certify that I have received, at this visit or a previous visit, a copy of Pro Sleep Care incorporated and Affiliated Notice of Privacy Practices.

If a representative is signing for the patient, list relationship and print name below:

_____ _____
(Print Name) **(Relationship to Patient)**

Patient Signature or Responsible Representative: **x**_____

Date: _____ Time: _____

Witness: _____ _____
(Print Name) **(Signature)**

PATIENT RIGHTS AND RESPONSIBILITIES

The rights of patient(s) include, but not limited to:

- To be treated with dignity and respect.
- To have all information kept confidential, related to care within required regulations.
- To be fully informed of the care and treatment provided by the physician and others.
- To receive care from professionally competent personnel; know the names and responsibilities of people giving the care.
- To be given an appropriate and professional quality testing and treatment.
- To receive a timely response to any reasonable requests you may make for services.
- To be given information about Pro Sleep Care's policies, procedures and charges for services.
- To be informed of the actual dollar amount of charges, if any, for which you may be liable.
- To have access, upon request, to all bills for services you have received regardless of whether the bills are paid out-of-pocket or by another party.
- To have the freedom of choosing your medical providers.
- To exercise your rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, the source of payment or utilization of services.
- To be free from physical and mental abuse and/or neglect.
- To receive the necessary information so you are able to consent to your service prior to the start of any services.
- To obtain complete and current information regarding their diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand.
- To participate actively in decisions to accept treatment. To the extent permitted by law, this includes the right to refuse treatment but to be informed of the expected consequences of that decision.
- To receive a care plan that will be developed to meet your unique care/service needs.
- To receive confidential treatment of all written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home. Written authorization of the member or authorized legal representative shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except as required by law.
- To review your clinical record at your request.
- To be given information regarding anticipated transfer of your home care to another vendor and/or termination of home care service to you.
- To participate in the consideration of ethical issues that arises in your care.
- To have your Advance Directive requests honored, designating another person to make medical decisions in the event you lose decision-making capacity. However, in the event your Advance Directive states "Do Not Resuscitate (DNR)", Pro Sleep Care employees are required to call 911 and start CPR, thus not honoring your DNR request.
- To have the freedom to voice your complaint or recommend changes in services, staff or in company policy without being threatened, and/or discriminated against, which will enhance or improve Pro Sleep Care.

The responsibilities of patient(s), but not limited to:

- To remain under a physician's care while receiving healthcare services.
- To inform the healthcare team of any changes in physicians involved in your care.
- To provide a complete and accurate health information concerning your past illnesses, hospitalization, medication, allergies, and other pertinent history.
- To participate actively in the development and update of your treatment plan.
- To provide the physician and healthcare company with all requested insurance and financial information.
- To sign the required consents and releases for insurance billing.
- To participate in the healthcare process by asking questions and expressing any concerns.
- To provide a safe home environment, when homecare is provided, in which care can be given.
- To accommodate and allow for any necessary changes in the home environment, when homecare is provided, to assure proper care.
- To cooperate with the physician, the healthcare team and other caregivers by complying with the required and agreed-upon therapy.
- To accept responsibility for any refusal of treatment.
- To treat the physician and other healthcare professionals with respect and consideration.
- To advise the privacy officer of Pro Sleep Care of any dissatisfaction or concerns about the care provided by calling (310) 922-4508.

Patient Name (Please Print):

_____

If a representative is signing for the patient, list relationship and print name below:

_____

Relationship to Patient Print Name

Signature of Patient or Responsible Representative:

x_____

Date: _____ Time: _____

Patient's Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of Pro Sleep Care's Notice of Privacy Practices with the effective date of July 01, 2012. Furthermore I will notify Pro Sleep Care of any special requests that I may have with regards to my privacy health information.

Signature of Patient/Patient Legal Representative: **x**_____

Print Name of Patient &/or Legal Representative: _____

Date: _____

Patient Financial Authorization and Release Form

Patient Information Regarding Billing

I hereby acknowledge that I am receiving or about to receive healthcare service. I understand that payment for services rendered on my behalf is my sole responsibility. I hereby authorize Pro Sleep Care or designated subsidiaries or agents to:

1. Bill my insurance provider and receive payment directly for all services rendered on my behalf.

2. Bill me for any amounts not paid by my insurance provider. These include, but are not limited to, copayment, deductibles, and non-covered services. I understand that these are determined by my insurance provider and policy, and I agree to be responsible for all resulting balances.

3. Bill me directly for any services denied by my insurance provider for pre-existing conditions.

4. Bill me directly for any services not paid within 60 days from the date of service for:

    - Workman's Compensation
    - Personal injury Claims
    - Auto Accident
    - Legal Action (contemplated, pending, or adjudicated)

Accepting Assignment
I understand that Pro Sleep Care will accept assignment for all covered services provided. Assignment is defined as "Reasonable and Customary Charge" for covered services. These are established by the insurance provider for the geographical area in which the service is provided.

Liability Release
I authorize access to all of my insurance information and medical records necessary for billing the related healthcare services. I hereby give permission to release any medical information or insurance information in order to file any insurance claims. I release Pro Sleep Care and its agents from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on me or my dependant to be paid directly to the provider and payment for services on my or my dependant behalf are my sole responsibility. I understand that a separate bill for interpretation may be sent for the interpreting physician.

I certify that I have read and understand the above information; understand my responsibilities; and have access to a copy of this form. I received (at this visit or a previous visit) a copy of Pro Sleep Care and Affiliates Notice of Privacy Practices and the Patient Bill of Rights.

Patient Name (Please Print):
_____

If a representative is signing for the patient, list relationship and print name below:

_____
Relationship to Patient Print Name

Signature of Patient or Responsible Representative:

X: _____

Date: _____ Time: _____