ADVANTAGE
Sleep Centers

1. Shower thoroughly, wash and dry your hair just prior to coming in for your test.

2. No oils, creams or lotions in or on your hair. Please call if you have a weave or wig attached to scalp.

3. Brush your teeth and bring night wear for sleeping in. We prefer that you wear loose fitting or pajama shorts with a loose fitting T-shirt or pajama top. **SWEATS ARE ACCEPTABLE.** ***Nudity is not acceptable.***

4. You should avoid caffeine throughout the day, and **absolutely NO caffeine should be consumed after 3:00 PM**. Products containing caffeine include coffee, tea, chocolate, soda, hot chocolate, etc.

5. You may eat dinner as usual; however do not eat for 2 hours prior to your appointment. Do not eat anything that would contain caffeine (i.e. chocolate, etc.).

6. Men, please try to be clean shaven. If you normally shave on a daily basis then clean shave on the night of your sleep study. If you normally have a beard or mustache, then you may leave it as is.

7. You may bring your own pillows/blanket if you like.

8. Do NOT use oils, creams or lotions from above the neck area.

9. Take medications as NORMAL. If you are currently taking sleep aids, et al. Please contact your referring doctor to determine if this is okay.

10. DO NOT TAKE NAPS DURING THE DAY OF THE TEST IF POSSIBLE.

11. The following will be needed at your appointment:
☐ Patient paperwork filled out—medication list, mailed paperwork, emailed paperwork.
☐ Bring your insurance card - a copy will be needed.
☐ Copay—check or cash only.
☐ Bring your prescription with you to your appointment, unless your physician has already faxed the prescription to ADVANTAGE SLEEP CENTERS 1-(866)-502-0052

12. Please be advised that Advantage Sleep Centers provides the diagnostic testing and our board certified sleep specialist provides the interpretation of your test. You will receive a separate Explanation of Benefits from your insurance carrier for each service.

ADVANTAGE
Sleep Centers

Cherry Hill · Voorhees · Sewell

Cancellations

Due to our extensive preparation for your sleep diagnostic testing at Advantage Sleep Centers, it is necessary for all of our patients to make every effort possible to keep their scheduled appointments.

Missed appointments or appointments not cancelled in an appropriate amount of time are a lost opportunity for us to help another patient. We ask that you make every effort to keep your scheduled appointment and to arrive on time.

It is our policy to charge for all missed appointments. A charge of $100.00 will be made to all patients who do not show for their appointment or do not call 48 hours prior to the appointment time.

Please understand that policy is due to our extensive preparation in getting you, our patient, the highest quality testing available.

Thank you,

Advantage Sleep Centers

ADVANTAGE Sleep Centers

Patient Questionnaire

Patient Name: ____________________

Date of Birth: ____________________

Medication	Dose	Frequency

When did your sleep problem begin and what are you experiencing?

____

____

Have you ever had a sleep study performed? Where?

____

What is your occupation? What are your work hours?

____

____

Sleep Times	During the week	Weekend
I go to bed at	☐AM ☐PM	☐AM ☐PM
I get up at	☐AM ☐PM	☐AM ☐PM
I sleep	hours	hours

ADVANTAGE
Sleep Centers

Patient Name: ____________________ Date of Birth: __________

Consumption	How much per night?	What time of day?
Alcohol	alcoholic beverages	☐AM ☐Lunch ☐PM ☐Prior to Bed
Caffeinated Beverages	☐Coffee ☐Soda ☐Other	☐AM ☐Lunch ☐PM ☐Prior to Bed
Smoking	cigarettes per day	

☒**Yes**	**Symptom/History Of:**	☒**Yes**	**Symptom/History Of:**
☐	I stop breathing in my sleep (witnessed apnea)	☐	previously diagnosed with sleep apnea
☐	mouth breathing	☐	currently using CPAP/BiPAP
☐	daytime naps	☐	cardiac arrhythmia (atrial fibrillation, PVCs, etc.)
☐	shortness of breath	☐	blood sugar disorder (diabetes, low sugar, high sugar)
☐	nightly coughing	☐	lung disease (COPD, asthma)
☐	irregular heart beat (palpitations)	☐	arthritis
☐	morning headache	☐	acid reflux (GERD)
☐	bed wetting	☐	high blood pressure (hypertension)
☐	concentration difficulty	☐	heart attack
☐	restless legs	☐	congestive heart failure
☐	sleep walking	☐	thyroid disease
☐	sleep talking	☐	teeth grinding
☐	nightmares	☐	anxiety/depression
☐	vivid dreams immediately upon waking or falling asleep (hypnagogic hallucinations)	☐	muscle weakness, triggered by emotions—laughing, crying, surprise, anger, etc. (cataplexy)
☐	episodes of being unable to move upon falling asleep or waking up (sleep paralysis)	☐	My snoring is: ☐mild ☐moderate ☐loud

ADVANTAGE Sleep Centers

Epworth Questionnaire

Patient Name: ____________________

Date of Birth: ____________________

Today's Date: ____________________

The **Epworth Sleepiness Scale (ESS)** determines how likely you are to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching Television	
Sitting inactive in a public place (i.e. a theatre or meeting)	
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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Patient Registration

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)** All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_________	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's SS #
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate ____/____/_____	Responsible Party's SS #
E-mail address			
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Spouse/Parent Birthdate ____/____/_____	Spouse/Parent SS #	Business phone
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:		Relationship to patient	Phone

Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] **If Yes-put W/C or MVA carrier below**	Date of Accident	Claim #	Case Worker's Name	W/C or MVA Insurance Phone #
Primary insurance company Address				Insurance Phone #
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address		Policy #		Group #

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Practice Name for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services

____ ___________________________

Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Practice Name for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ ___________________________

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

I authorize Advantage and/or our agents to contact me by telephone at any number associated with my account, including wireless telephone to collect monies I may owe. Methods of contact may include pre-recorded/artificial voice messages and the use of automatic dialing device, as applicable.

____ ___________________________

Patient, Parent or Guardian Signature Date

HOW DID YOU HEAR ABOUT US?

PHYSICIAN ____ **FAMILY/FRIEND** ____ **NEWSPAPER AD** _____ **YELLOW PAGES** ____ **OTHER** _______

ADVANTAGE
Sleep Centers

Patient Information Acknowledgement

Patient Name: ____________________

Date of Birth: ____________________

Advanced Directives/DNR

Please be advised that Advantage Sleep Centers has an emergency policy and procedure which indicates that 911 will be called for all patient emergencies. We request that all patients, upon admission, supply Advantage Sleep Centers with copies of their Advanced Directives to retain in their electronic medical chart so that in the event of a 911 emergency we can give your directives to the Emergency Transit Team.

Do you have an Advanced Directive/DNR Instructions? ☐ Yes ☐ No

Copies provided to Advantage Sleep Centers? ☐ Yes ☐ No

_________________________________ ____________________

Patient Signature Date

Privacy Act/HIPAA

By signing below I acknowledge that I have been offered a copy of Advantage Sleep Center's notice of Privacy Practices.

_________________________________ ____________________

Patient Signature Date

ADVANTAGE
Sleep Centers

Dear Advantage Sleep Center Patient,

In accordance with the new Federal regulations regarding a patient's privacy, please read and sign below.

I, ______________________________________, give permission to Advantage Sleep Centers and its Medical Director's offices to do the following:

- Confirm appointments by phone
- Leave messages on answering machine to confirm appointments
- Leave sleep test results on answering machine
- Leave messages to return Physician's calls
- Release medical information requested by other treating physicians or healthcare institutions
- Request records from other medical offices or institutions

____
Printed Name

___________________ _________________________________
Date Signature

ADVANTAGE
Sleep Centers

Authorization to Release Medical Record Information & Consent

Patient Name: ____________________

Date of Birth: ____________________

I authorize Advantage Sleep Centers to release my medical records to the mentioned physicians.

Physician	Address	Phone/Fax

Read Carefully: I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person(s) specified above. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization, I am allowing the release of any drug, alcohol, or psychiatric information records to the agency or person(s) specified above. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted disease by signing this authorization, I am allowing this information to be released to the agency or person specified above. I also understand that I may revoke this authorization at any time by written request from myself or my family except to the extent that action has already been taken in reliance upon it.
This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me (the signed). If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

____________________________________ ____________________

Patient Signature Date

I grant permission for Advantage Sleep Centers to perform testing and/or procedures necessary for the accurate diagnosis and/or treatment of any sleep disorder I may have.

I understand video and audio recording are included as a necessary part of the sleep study and I grant permission for such recording. The video and audio recording are considered medical information will be retained as part of my permanent medical record.

I understand that these records are considered private medical information and will be kept confidential in accordance with HIPAA regulations and shared with authorized persons and entities in accordance with HIPAA regulations.

____________________________________ ____________________

Patient Signature Date