

SCA | Sleep Clinics of America

NEW PATIENT PAPERWORK

Date: _____

Name: _____ DOB: _____ AGE: _____
Last First M.I.

Social Security Number: _____ Gender: M F

Marital Status: Single Married Divorced Separated Widowed Partner

Spouse/Partner Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best contact: Cell Home Work

Preferred Pharmacy/Phone: _____

Email Address: _____

Employer: _____ Employment Address: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

How did you find out about us? _____

Family physician and number: _____

Referring physician and number: _____

Insurance Carrier: _____ Member ID: _____

Contract/Group # _____ Referral needed? Y N

Complete below if you are **not** the primary insurance holder:

Primary Insured Name: _____ Relationship to you: _____

Address: _____

SSN of insured: _____ Employer of insured: _____

Reason for visit: _____ How long: _____

SYMPTOMS

(Check all that apply)

- Snoring Pauses/irregular/stop breathing at night Wake up choking/gasping/coughing
- Feel tired after naps
- Problems with memory, concentration or irritability during the daytime.
- Feel weak, tired, or fall down suddenly when laughing, telling a joke, getting upset/excited, or when surprised.
- Awakened without ability to move your arms and legs (completely paralyzed) for a short time.
- Felt as though you were "seeing things" that were not there at either the time of falling asleep or waking up.
- Kick, punch, scream, fall out of bed, sleepwalk, or eat in your sleep (and found out about later).
- Unpleasant sensations or aching in your legs when resting or the evening.
- Other: _____

Sleep routine before bedtime: watch tv read eat on phone other: _____

How is the room when you sleep: quiet dark cold Fan/TV other: _____

Sleep Schedule	Bedtime (lights out)	Approx. time to fall asleep	Wake-up Time	<input type="checkbox"/> Shift Work
Weekday				
Weekend				

PAST MEDICAL HISTORY

(Mark any that you have now or in the past)

- Diabetes Heart Disease Defibrillator Pacemaker Afib/Flutter Cholesterol Hypertension
- Hypothyroidism Stroke or TIA Seizures COPD Asthma Cancer Kidney Disease
- Depression Anemia Anxiety Nasal allergy Sinuses GERD Ulcer Disease
- Migraines Fibromyalgia Parkinson's Other: Other:

MEDICATIONS

(including non-prescription medicines, supplements and birth control pills or attach a list)

Med Name	Dose	Frequency

Allergies (write NONE if no allergies): _____

PATIENT NAME: _____

Date of Birth: _____

Surgeries (if any): _____

FAMILY HISTORY

Father: Living – Illness: _____ Deceased - Cause of death: _____

Mother: Living – Illness: _____ Deceased - Cause of death: _____

SOCIAL HISTORY

Tobacco: _____ Alcohol: _____

Caffeine: _____ Recreational Drugs: _____

NOTICE OF PRIVACY PRACTICES – PROTECTED HEALTH INFORMATION

Sleep Clinics of America (SCA) strives to maintain the privacy of all our patients. We will use and disclose your Protected Health Information (PHI) in one or more of the following: to facilitate your treatment, to obtain payment, Healthcare operations, Law Enforcement, and Public health reporting

Patient Rights: I understand that I may request a restriction on the use of my PHI. I understand that I have the right to receive confidential communications regarding my medical conditions and treatment. I understand that I have the right to inspect and copy my PHI. I understand I have the right to amend and submit corrections to my PHI. I have the right to receive an accounting of how and to whom my PHI has been disclosed. I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by SCA. I consent to authorize SCA to request any medical records from other health care providers.

All requests listed above must be made in writing to: Sleep Clinics of America, 8002 Discover Drive, Suite 215, Richmond, VA 23229

SCA reserves the right to change the terms of its Notice of Privacy Practices and to make new versions effective for all protected health information that it maintains at any time without prior notification.

Signature: _____ **Date:** _____

MEDICATION REFILL AND USE POLICY

Modification of a prescription or use/abuse of a medication against its intended use is not allowed. Should Sleep Clinics of America, LLC (SCA) become aware of such a deviance, your care with SCA may be terminated and you may risk prosecution by state and federal laws. Furthermore, SCA will not be responsible for illicit actions and may be forced to present data to law enforcement authorities.

Refill requests should be made to the dispensing pharmacy and not to the office. All refill requests require a minimum of 48-hour notice and will be completed during normal business hours only. You must be seen and evaluated by a physician in the office within the last 90 to 180 days in order to make a refill request. Additionally, narcotic medication or other controlled substances will require a follow up visit for every refill request. Your treating physician reserves the right to authorize or discontinue a refill request.

Controlled Substance Medication Agreement – I will not request nor accept controlled substance medications from any other physician or individual while I am receiving such medications from SCA. Furthermore, I will not give, share nor sell my medications to any other person.

My signature below acknowledges that I have read, understood and agreed with the above stated policy.

Signature: _____ **Date:** _____

PATIENT DISCLOSURE AUTHORIZATION FORM

I authorize disclosure of my protected health information only in the following manner and to the individuals listed below:

Voice messages with my protected health information may be left at this number: _____

Person(s) to whom this practice may disclose my protected health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I consent to have my medical information transferred to any physician and/or health care institution that I am referred to by Sleep Clinics of America, LLC (SCA). I consent to authorize SCA to request any medical records from other health care providers. This authorization will be in effect until such time as I authorize in writing to: Sleep Clinics of America, 8002 Discovery Drive, Suite 215, Richmond, VA 23229

Signature: _____ **Date** _____

PATIENT FINANCIAL RESPONSIBILITY AND NO-SHOW POLICY

Your signature below forms a binding agreement between Sleep Clinics of America, LLC (SCA) and the Patient, who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

The person signing on behalf of the Patient as the Responsible Party (RP) must inform SCA of the current address and phone number for the patient and the responsible party, provide all current insurance cards prior to each office visit, and pay any additional amount owing within 30 days of receiving a statement from our office.

All copays and deductibles for services rendered are due and payable prior to service. You are responsible if your insurance company declines to pay for any reason.

Insurance plans with Deductibles – If your current insurance plan has a deductible, you shall be responsible for the following pre-payment **PRIOR** to services being rendered: \$150 New Patient Visit, \$100 Follow-up Visit, \$150 Home Sleep Test, \$350 for In-lab/overnight Sleep Test. These charges are not considered full payment of service. As directed by your insurance plan, you may be responsible for the remaining balance, if any.

Missed Appointments – SCA shall be notified at least 24 hours in advance to cancel or change an appointment, otherwise a service fee of \$50.00 shall be charged and payment will be due within thirty days. Services shall not be rendered until this fee is paid in full.

Records Request – A request for medical records will incur a \$60 charge for the first 30 pages and \$0.30 per page thereafter. Records request will only be completed upon written consent of authorized party.

Request for Signature/Signature Forms – **ANY** request for Physician or Provider to sign any paperwork will be charged a \$50 fee. Signature request will be fulfilled no earlier than 2 business days after the request or form is received by SCA. Disability paperwork, public utility priority paperwork, etc will **not** be authorized by SCA.

Returned Checks - The patient or the RP will be responsible for the original check amount plus a \$35.00 Service Charge for any check returned due to Non-Sufficient Funds. Additionally, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance (which shall include the \$35.00 returned check fee)

Non-Payment on Account - Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the RP, understands that SCA has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the RP, understands that they are responsible for all costs of collection including, but not limited to all court costs, attorney fees, and a collection fee of 50% will be added to the outstanding balance.

Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Print): _____

Responsible Party Name (Print): _____

Responsible Party Signature : _____ **Date:** _____