SCA | Sleep Clinics *of* America

NEW PATIENT PAPERWORK **Date:** _____

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

Social Security Number: _____ Gender: □ M □ F

Martial Status: □Single □Married □Divorced □Separated □Widowed □Partner

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Best contact: □Cell □Home □Work

Email Address: _____

Occupation: _____ Employer: _____

Employment Address: _____

Spouse Name: _____

Emergency Contact: _____ Phone: _____

How did you find out about us? _____

Family physician and number: _____

Referring physician and number: _____

Preferred Pharmacy/Phone:

Primary Insurance Carrier: _____Member ID: _____

Secondary Insurance Carrier: _____ Member ID: _____

Referral needed? □ Y □ N, IF NEEDED: PLEASE OBTAIN PRIOR TO APPOINTMENT

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

Primary Insured Name: _____ Relationship to you: _____

Address: _____

Date of Birth 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 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	☐ 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**

Height: _____ Weight: _____ **Allergies** (write N/A 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 authorizing 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 Discovery 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

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 (about 6 months)** 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.

Modification of a prescription or use/abuse of a medication against its intended use is not allowed. Should Sleep Clinics of America, Inc. (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.

Your signature below acknowledges that you 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, Inc. I consent to authorize Sleep Clinics of America, Inc. To request any medical records from other health care providers. This authorization will be in effect until such time as the patient requests another authorization 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, Inc. (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 RP, 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 due to lapse in coverage, or lacking referral from your PCP (Primary Care Physician).

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: **$100** for each of the following services**: New Patient Appointment, Follow-Up Appointment, Home Sleep Test, 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 Appointment: SCA shall be notified at least 24 hours in advance to cancel or change an appointment, otherwise a service fee of $100 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 in paper format will incur a $20 search and handling fee, $0.50 per page for up to 50 pages, $0.25 a page thereafter and all postage and shipping costs. If your request is for electronic records, it will incur a $20 search and handling fee, $0.37 per page for up to 50 pages and $0.18 a page thereafter.

Request for Signature/Signature Forms: **ANY** request for Physician or Provider to sign any paperwork will be charged a $30 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 of 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: _____