

# 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

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: \_\_\_\_\_ Member ID: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ 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: \_\_\_\_\_

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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

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: \_\_\_\_\_

### The Epworth Sleepiness Scale - measures how **sleepy** you are

Sleepiness is one of the main disabling symptoms of OSA

How likely are you to doze off or fall asleep in the following situations, in comparison 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 try to work out how they would have affected you.

Score yourself for each of the eight situations below, use the following scoring system:

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Situation	Score
Sitting and reading	
Watching television	
Sitting inactive in a public place, e.g. theatre or meeting	
As a passenger in a car for an hour without a break	
Lying down in the afternoon, when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
<b>TOTAL</b>	

## 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 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

**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, LLC 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:** \_\_\_\_\_