



Dear Patient,

You have an upcoming appointment on _____ at _____ AM / PM with a Sleep Insights provider at:

Sleep Insights, 755 Jefferson Road, Suite 110, Rochester 14623

Enclosed are the First Appointment documents that will need to be completed prior to seeing your provider (Patient Sleep Questionnaire, Patient Financial Responsibility Agreement, and HIPAA/Privacy Packet). *If you do not complete them before to your visit, please plan on arriving 10 minutes prior to your appointment.*

If you had a sleep study from another location or have any other pertinent records that should be available for the provider at your appointment, please complete a Release of Records Form and send it to us so we can contact that facility/provider and receive your records in our office prior to your appointment.

Please bring:

- Photo ID
- Insurance card(s)
- A list of medications you are currently taking
- A method of payment for your visit. *Co-pays, co-insurance or deductibles are due at the time of visit, prior to seeing the provider.*
- If you have a CPAP machine, *bring it to every appointment.*

Sleep Insights requires 24 hours notice for any cancellation; otherwise, you will be charged a \$50 no-show fee for office visits and \$100 no-show fee for sleep studies.

If you are later than 15 minutes for your appointment, please be aware we will have to reschedule your appointment.

Please contact our office with any questions: **585.385.6070**. We look forward to seeing you.

The Providers and Staff at Sleep Insights

DIRECTIONS to 755 JEFFERSON ROAD, SUITE 110, ROCHESTER 14623

From 390 heading north:

- Take the I-390 N toward Rochester
- Take the Hylan Dr exit, EXIT 13
- Turn left onto Hylan Dr/County Hwy-263
- Turn right onto Jefferson Rd/NY-252
- 755-765 Jefferson Rd, Rochester, 14623 is on your right, across from the Marshall's / Home Depot Plaza
- DO NOT PARK BY OR GO INTO THE MAIN ENTRANCE. When you pull in, immediately turn left and head east toward our entrance, which faces Jefferson Road. Park in the east side parking lot (the one closest to the large Sleep Insights sign facing Jefferson Rd). You can access our office from the front door underneath the large Sleep Insights sign.

From 390 heading south:

- Take the I-390 S
- Take the NY-15A/E Henrietta Rd exit, EXIT 16B
- Turn right onto E Henrietta Rd/NY-15A
- Turn right onto Jefferson Rd/NY-252
- Make a left U-turn on Jefferson Rd/NY-252 at the Market Square Plaza light (entrance to Marshalls / Bed Bath & Beyond / Michael's / DSW)
- 755-765 Jefferson Rd, Rochester, 14623 is on your right, across from the Marshall's / Home Depot Plaza
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From the west (no expressway):

- Take NY-252/Jefferson Rd toward Rochester
- 755-765 Jefferson Rd, Rochester, 14623 is on your right, across from the Marshall's / Home Depot Plaza.
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From 590 heading south:

- Take I-590 S
- Merge right onto I-390 S toward I-90/Corning
- Take the NY-252/Jefferson Rd exit
- Turn right onto Jefferson Rd/NY-252
- Make a left U-turn on Jefferson Rd/NY-252 at the Market Square Plaza light (entrance to Marshalls / Bed Bath & Beyond / Michael's / DSW).
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NEW PATIENT INFORMATION

Phone: (585) 385-6070 / Fax: (585) 385-6071
SleepInsights.com

This requested information is very important for the sleep specialist reviewing your sleep symptoms and data. Please respond to all questions. This information is treated with the utmost discretion and will not be used by any party other than Sleep Insights.

DEMOGRAPHICS

Today's Date _____ Sex ___ F ___ M Date of Birth _____
 Last Name _____ First Name _____
 Address _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____
 Cell Phone _____ Email _____
 Height _____ ft _____ in Weight _____ lbs
 Marital status: ___ single ___ married ___ divorced ___ widowed
 First Language: ___ English ___ Spanish ___ Other: _____

REFERRING PROVIDER

Healthcare provider or dentist who referred you to Sleep Insights:

A medical/dental provider did not refer me

Name _____ Address _____
 Phone _____
 Is this a ___ medical provider ___ dentist? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired?

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			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. a movie theater)	0	1	2	3
As a car passenger for more than one hour without a break	0	1	2	3
Lying down to rest in the afternoon	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, stopped for a few minutes in traffic	0	1	2	3

Score Key: Total Score _____ 1–10 Normal Range 10–12 Borderline 12–24 Abnormal

Have you ever had a sleep study before? Yes No

If yes, please bring a copy of the study to your appointment if you have it.

If so, when and where? _____

Have you had any prior treatment for sleep apnea? If so, please list:

SLEEP PROBLEMS (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Gasping/choking/repeated pauses in breathing while sleeping |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Unusual behavior(s) during sleep (walking, talking, etc.) |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Dozing while driving/motor vehicle accidents related to dozing while driving |
| <input type="checkbox"/> Tired/sleepy during the day | <input type="checkbox"/> Leg movements before/during sleep |
| <input type="checkbox"/> Morning headache | |
| <input type="checkbox"/> Other: _____ | |

Briefly describe your sleep-related problem:

WORK INFORMATION

What is your current employment status?

in school unemployed employed part time employed full time retired disabled

Occupation _____

What is your predominant work schedule?

Day shift (9am – 5pm) Variable schedule
 Evening shift (3pm – 11pm) Night shift (11pm – 7am)

Do you work:

Night shifts: never rarely occasionally frequently always
Irregular shifts: never rarely occasionally frequently always

SLEEP HABITS

	Work Day	Non-Work Day
What time do you get into bed?	____ am pm	____ am pm
What time do you turn off the lights to go to sleep?	____ am pm	____ am pm
What time do you get out of bed to start the day?	____ am pm	____ am pm
How many hours do you actually spend in bed?	_____	_____
How many hours do you think you actually sleep?	_____	_____
Do you have a regular bed partner?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SOCIAL HABITS

When do you usually drink your last cup of caffeinated beverage each day?

Coffee ___ cups per day I drink my last cup no later than ___ am / pm
Tea ___ cups per day I drink my last cup no later than ___ am / pm
Soda ___ cups per day I drink my last can no later than ___ am / pm

How many alcoholic beverages do you have each *day* on average?

Beer ___ 12 oz. serving
Wine ___ 4 oz. serving
Mixed drinks ___ drinks (one drink has 1.5 oz. liquor)

Tobacco use: ___ never used tobacco products ___ cigarettes ___ cigars ___ pipes ___ snuff

History: ___ currently smoke ___ quit smoking year quit: _____

How many packs / cigarettes (please circle) per day did / do you smoke? _____ Number of years? _____

Drug use? If so, please specify:

How many days per week do you exercise 30 minutes or more?

___ 0 days ___ 1–2 days ___ 3–4 days ___ 5–7 days

HEALTH

Have you ever been diagnosed with any of the following? Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies/nasal/sinusitis | <input type="checkbox"/> Diabetes ^{SEP} | <input type="checkbox"/> IBS (Irritable Bowel Syndrome) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney disease ^{SEP} |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart disease (angina, heart attack, stents, CABG) | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Benign Prostate Hypertrophy | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> History of addiction | <input type="checkbox"/> PTSD (Post-traumatic stress disorder) |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Restless legs syndrome |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Hyperthyroidism (over-active thyroid) | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Hypothyroidism (under-active thyroid) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Incontinence (loss of bladder control) | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Other: ^{SEP} _____ |
| <input type="checkbox"/> Depression | | _____ |

MEDICATION

Medication allergies: _____

Any contact allergies (ex. tape, Band-Aids)? _____

Please list any medications you are currently using or attach a medication list:

Medication with dosage: _____ Medication with dosage: _____

Medication with dosage: _____ Medication with dosage: _____

Medication with dosage: _____ Medication with dosage: _____

Medication with dosage: _____ Medication with dosage: _____

Medication with dosage: _____ Medication with dosage: _____

Medication with dosage: _____ Medication with dosage: _____

FAMILY HISTORY

Please identify any medical problems that have occurred in your immediate family (blood relatives only). This should include your parents, grandparents, brothers/sisters, and children. If you have an aunt/uncle who had a major medical problem you would like to describe, list it under "other".

	Mother	Father	Grandmother		Grandfather		Brother	Sister	Son/daughter S=son; D=daughter
			Maternal	Paternal	Maternal	Paternal			
Insomnia	___	___	___	___	___	___	___	___	___
Seizure/epilepsy	___	___	___	___	___	___	___	___	___
Parkinson's Disease	___	___	___	___	___	___	___	___	___
Depression	___	___	___	___	___	___	___	___	___
Cancer	___	___	___	___	___	___	___	___	___
Asthma	___	___	___	___	___	___	___	___	___
Anxiety	___	___	___	___	___	___	___	___	___
Dementia	___	___	___	___	___	___	___	___	___
RLS	___	___	___	___	___	___	___	___	___
Hypertension	___	___	___	___	___	___	___	___	___
Heart disease	___	___	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___	___	___
Sleep apnea	___	___	___	___	___	___	___	___	___
Diabetes mellitus	___	___	___	___	___	___	___	___	___

Other: _____

PHYSICIAN / PHARMACY INFORMATION

Primary Care Provider	Pharmacy
Name _____	Name _____
Address _____ _____	Address _____ _____
Phone _____	Phone _____



HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). **Jacob Dominik MD, PLLC d/b/a Sleep Insights** Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

Jacob Dominik MD, PLLC d/b/a Sleep Insights needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below. We will witness your signature.

Print Patient Name (and Guardian name if applicable)

Patient Date of Birth

I give my consent for **Jacob Dominik MD, PLLC d/b/a Sleep Insights** to use and disclose my PHI to carry out TPO. With this consent **Jacob Dominik MD, PLLC d/b/a Sleep Insights** may mail items or call my home (or other alternate locations) to facilitate treatment, payment, and healthcare operations. They may leave messages concerning healthcare information (such as appointment reminders, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

___ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to Jacob Dominik MD, PLLC d/b/a Sleep Insights to also specifically speak with:

___ spouse: _____

___ relative: _____

___ other: _____

Jacob Dominik MD, PLLC d/b/a Sleep Insights may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

Signature of Patient

Date



PATIENT RESPONSIBILITY AGREEMENT

The doctors and staff of Jacob Dominik, MD, PLLC (a.k.a. Sleep Insights) appreciate the confidence you've shown in choosing us to provide for your medical care. We're committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

The patient (or patient's guardian, if a minor) is responsible for payment for his/her treatment and care.

- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of the service. We accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover.
- **ONLY patients with high deductible plans who haven't met their deductible must pay the following at time of service:**

- \$150 is due at time of service for all consults
- \$50 is due at time of service for all follow-ups
- \$100 at the time of scheduling for all sleep studies

Any overpayments will be applied to future dates of services or refunded in full.

- Patients may incur and are responsible for the payment of the following additional charges:
 - A \$40 fee for all returned checks.
 - A \$50 fee will be applied towards all no-show office visits and \$100 fee for all no-show sleep studies. While we understand there may be times when you miss an appointment due to emergencies or obligations, Sleep Insights requires a 24-hour notice for all cancelled appointments.
- Patients may be discharged from the practice if two (2) or more appointments are no-showed.

INSURANCE

The following are the patient's responsibility:

- Patients must bring their insurance card to each visit
- Notify our office of any changes to insurance/address/phone numbers
- If there is a change in insurance and we are not notified prior to the change or we do not accept the new insurance, patient may be responsible for payment in full
- Know copays, benefits and coverage and determine if doctor(s) are in-network providers prior to first visit
- Pay for any allowed amounts not covered by insurance

If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.

PATIENT AND EMPLOYEE SAFETY

We must assure a safe work environment for our employees. Sexual advances and/or physical assault of any kind upon any of our staff members will result in immediate discharge from our clinic. Discharge in these cases will be at the sole discretion of the treating provider.

CELL PHONE USE CONSENT

Jacob Dominik, MD PLLC may contact the patient's cell phone regarding appointments, test results, billing inquiries and any other matter associate with the patient's account. Cell phones may not be used for personal audio or video recording of office visits or in-lab testing.

I have read, understand and agree to the provisions of this Patient Financial Responsibility Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Jacob Dominik, MD, PLLC reserves the right to change or amend this statement at any time and at its discretion.

X

Signature of Patient/Responsible Party

Print Name

Date



REQUEST FOR RELEASE OF MEDICAL INFORMATION

I DECLINE. I DO NOT HAVE ANY MEDICAL RECORDS TO BE SENT TO SLEEP INSIGHTS.

Please release a copy of my medical record to:

Name of Doctor, Medical Practice or Individual:

Jacob Dominik, MD, PLLC, Sleep Insights

Mailing Address of Requested Recipient:

755 Jefferson Road, Suite 110, Rochester, NY 14623

Phone Number of Recipient:

585-385-6070

Facsimile Number (Fax) of Recipient:

585-385-6071

Patient Signature (or signature of legal guardian):

Printed Name of Patient:

Date of Birth:

PLEASE NOTE THE FOLLOWING:

You can always obtain a copy of your personal medical information for your own records. Once your medical records are in your possession you may copy them and deliver them according to your preferences. Your confidential medical information will only be sent to the place you have indicated on this form; please ensure that the address and/or fax number is accurate. Please allow us ten days to process a routine request. If more urgency is needed, we will attempt to expedite your request.