Dear Patient,

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

***Sleep Insights, 47A Batavia City Centre, Batavia, 14020***

**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: **585.219.4330.** We look forward to seeing you.

The Providers and Staff at Sleep Insights

## DIRECTIONS to 47A BATAVIA CITY CENTRE

**Heading east, from Pembroke:**

- Take the NY-5/Main Rd east toward Batavia
- Turn left onto Jefferson Ave (at the corner of Wendy's and Batavia City Centre)
- Take next right into parking lot for 47A Batavia City Centre

**Heading west, from Caledonia:**

- Take the NY-5/Main Rd west toward Leroy/ Batavia
- Turn right onto Jefferson Ave (at the corner of Wendy's and Batavia City Centre)
- Take next right into parking lot for 47A Batavia City Centre

**Heading southwest, from Brockport:**

- Take the NY-19/Main Rd south toward Bergen
- Turn right onto NY-33/Clinton St Rd
- Turn right onto NY-5/East Main St in Batavia
- Turn right onto Jefferson Ave (at the corner of Wendy's and Batavia City Centre)
- Take next right into parking lot for 47A Batavia City Centre

**Heading north, from Alexander:**

- Head north on NY-98 and follow for approximately 8 miles
- Turn left onto NY-98/S. Main St in Batavia
- Enter next roundabout and take the 1st exit on onto NY-33/NY-98/Oak St
- Turn right onto NY-5/W Main St and follow
- Turn left onto Jefferson Ave (at the corner of Wendy's and Batavia City Centre)
- Take next right into parking lot for 47A Batavia City Centre

# NEW PATIENT INFORMATION

Phone: (585) 219-4330/ Fax: (585) 310.7447
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)

____ Snoring
____ Difficulty falling asleep
____ Difficulty staying asleep
____ Tired/sleepy during the day
____ Morning headache
____ Gasping/choking/repeated pauses in breathing while sleeping
____ Unusual behavior(s) during sleep (walking, talking, etc.)
____ Dozing while driving/motor vehicle accidents related to dozing while driving
____ Leg movements before/during sleep
____ 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? | ____ Yes | ____ 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 week 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.

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

_____

## 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 |
|---|---|---|---|---|---|---|---|---|---|
| | | | 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**

Name_____

Address _____

_____

_____

Phone_____

**Pharmacy**

Name _____

Address _____

_____

_____

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**

sleepinsights
Practicing Medicine. Perfecting Sleep.

# 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 records to:***

Name of Doctor, Medical Practice or Individual:
**Jacob Dominik, MD, PLLC, Sleep Insights**

Mailing Address of Requested Recipient:
**47A Batavia City Centre**

Phone Number of Recipient:
**585.219.4330**

Facsimile Number (Fax) of Recipient:
**585.310.7447**

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.