Dear Patient,

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

Sleep Insights, 2625 Delaware Avenue, Suite 104, Buffalo, NY 14216

Enclosed are the First Appointment documents that will need to be completed prior to seeing your provider (Patient Sleep Questionnaire, HIPAA Consent Form, Patient Financial Responsibility Agreement, Release of Medical Information Form, Medication Consent Form, and Review of Systems). *If you do not complete them before 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: **716.332.0404.** We look forward to seeing you.

The Providers and Staff at Sleep Insights

NEW PATIENT INFORMATION

Phone: (716) 332.0404/ Fax: (716) 871.1998
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

First Language: ____ English ____ Spanish Other: _____

Marital Status
____ Single
____ Married
____ Divorced
____ Widowed

Race (Origin)
____ African American
____ Asian/Pacific Islander
____ Caucasian
____ Hispanic
____ Other

First Language
____ English
____ Spanish
____ Other: _____

PHYSICIAN / PHARMACY INFORMATION

Primary Care Provider

Name_____

Address _____

_____

_____

Phone_____

Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Were you referred by a: ____ Physician/NP/PA ____ Dentist

If so, please provide name and/or practice name:

_____

Do you require paperwork stating that you are safe to drive? ____ Yes ____ No

Revised Apr 15. 2018

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

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

SLEEP PROBLEMS

Reason for today's sleep evaluation:

_____

_____

_____

SLEEP and HEALTH HABITS

	Work Day	**Non-Work Day**
What time do you get into bed?	____ am pm	____ am pm
What time do you get out of bed to start the day?	____ am pm	____ am pm
How many times do you wake up at night, on average?	____ times a night	
Is there a family history of sleep disorders?	____ Yes	____ No

If so, please describe:

_____

_____

I tend to:

____ Snore loudly
____ Wake up with heart racing
____ Wake up feeling sweaty
____ Feel sleepy during the daytime.
____ Take naps
____ Urinate frequently during the night
____ Have periods of breathing pauses
____ Wake up with headache
If so, does sleepiness affect: mood memory (circle one or both)
If so, how many per week: _____ How long on average:_____

I am a: _____ smoker _____ non-smoker
I drink: _____ alcoholic beverages per *week* _____ caffeinated beverages per *day*

I live with: _____

Occupation: _____

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**

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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

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MEDICATION CONTRACT

This agreement is an essential factor in maintaining the trust and confidence necessary in my provider-patient relationship.

I agree to the following statements:

1. I will be responsible for calling the office during regular office hours for my medication refills **at least 4 business days** before the end of my medication. Business days are Monday through Friday--they do not include weekends and holidays.

2. I understand that I must keep my medication in a safe place. Lost or damaged medications will not be replaced. If my medications are stolen, the prescription may be refilled one time only if a copy of the police report of the theft is submitted to the provider's office.

3. I agree not to sell, lend or in any way give my medication to any other person.

4. Early refills or emergency refills will not be given.

5. I agree to use only one pharmacy to fill my medication. List pharmacy name and address:

   _____

   _____

6. I agree that I will attend all required follow-up appointments with my provider to monitor the medications and I understand the failure to do so will result in discontinuation of the treatment and I may be discharged from the practice.

7. I will only consume alcohol in moderation, unless when taking Xyrem, at which time I will refrain from drinking alcohol completely.

8. **For non-controlled medications, I will have my pharmacy fax a refill request to the office.**

I understand that I may terminate this agreement at any time. If my provider decides that the medication is not helping me, the medication may be stopped by my provider in a safe way.

I have read the above. I have asked questions, and I understand the agreement. If I violate the agreement, I understand that the provider may discontinue the medication(s) and discharge me from the practice.

_____ _____

Patient signature **Date**

_____ _____

Provider signature **Date**

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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 Sleep Insights medical record to:

Name of Doctor, Medical Practice or Individual:
Kenneth Halliwell, MD (Jacob Dominik, MD, PLLC, a.k.a. Sleep Insights)

Mailing Address of Requested Recipient:
2625 Delaware Avenue, Suite 104, Buffalo NY 14216

Phone Number of Recipient:
716.332.0404

Facsimile Number (Fax) of Recipient:
716.871.1998

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.