



Dansville Location
Dr. Kenneth Halliwell

Dear Patient,

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

***Noyes Memorial Hospital, 111 Clara Barton Street, Second Floor Sleep Disorders Center,
Dansville, NY 14437***

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

Please return completed documents in the pre-stamped envelope included with this packet.

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.

Please contact our office with any questions: **585.335.4285**. We look forward to seeing you!

The Providers and Staff at Sleep Insights

**DIRECTIONS TO 111 Clara Barton Street, DANSVILLE
ARE ON THE BACK OF THIS LETTER**

DIRECTIONS to 111 CLARA BARTON STREET DANSVILLE NY 14437

From 36 heading North:

- Take 36 North from Hornell to Dansville
- Turn Right into hospital driveway
- Enter Hospital from Saunders Surgical Center Entrance in front of hospital
- Take Elevators to second floor (button 2F on elevator) and follow signs for Sleep Center

From 390 heading South:

- Take I-390S toward Dansville
- Take EXIT 4, toward NY-36 toward Dansville/Hornell
- Turn left onto NY-36/Clara Barton Street
- Turn Right into hospital driveway
- Enter Hospital from Saunders Surgical Center Entrance in front of hospital
- Take Elevators to second floor (button 2F on elevator) and follow signs for Sleep Center



NEW PATIENT INFORMATION

Phone: (585) 335.4285/ Fax: (585) 335.4290
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

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:

<input type="checkbox"/> Snore loudly <input type="checkbox"/> Wake up with heart racing <input type="checkbox"/> Wake up feeling sweaty <input type="checkbox"/> Feel sleepy during the daytime. <input type="checkbox"/> Take naps	<input type="checkbox"/> Urinate frequently during the night <input type="checkbox"/> Have periods of breathing pauses <input type="checkbox"/> 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: _____
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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



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 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:

Sleep Disorders Center at Noyes, 111 Clara Barton Street, Dansville, NY 14437

Phone Number of Recipient:

585.335.4285

Facsimile Number (Fax) of Recipient:

585.335.4290

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.