SLEEP LAB REGISTRATION

Please completely fill out the information below

Last Name: _______________________________ First Name: _______________________________ Date: ______________

Address: ____ Zip: ______________

Home Phone: ______________________ Work Phone: _____________________ Cell Phone: _______________________

SS#: _______________________________ DOB: _________________ Age: ___________ Sex: Male ☐ Female ☐

Height: ___ft. ______in. Weight: _______ lbs. Current Working Status: Working ☐ Retired ☐ Disabled ☐

Email Address: ____ Check to enroll in Patient Portal ☐

Circle one: Single Married Divorced Widowed Separated

Emergency Contact: ____ Contact Phone: _____________________

Referring Physician: ____ Phone: __________________________

Address: ____

Medical Insurance: Insurance Carrier: ____

Policy Holder: ____ Relationship: ___________________________

SS#: ___________________________ DOB: ______________ Policy Holder's Employer: _____________________________

Policy ID#:____ Group #:______________________________________

Medications: ____

____

Past Medical History/ Surgeries: ____

____

Allergies: ____

____

• *6713 Collamer Road, East Syracuse, NY 13057* •

P: (315) 463-0421 *F: (315) 463-0466* *ghalyhwc.com*

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze off or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would affect you.

Use this 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

It is important that you circle a number (0-3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place- for example, a theater or meeting	0 1 2 3
As a passenger in a car for an 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 (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
	Total Score:

Jacob Dominik, MD, PLLC d/b/a Sleep Insights
755 Jefferson Road, Suite 110, Rochester, NY 14623
585.385.6070

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 Ghaly Sleep Center/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

  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.
  - Phone follow up appointments with a provider may be a billable charge.
  - 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.
  - Home Sleep Tests that are not returned the following day will incur a $50 late fee PER day.
- Patients may be discharged from the practice if two (2) or more appointments are no-showed.

PLEASE NOTE: All claims and billing are processed out of our Rochester office under the business name *Jacob Dominik MD PLLC/Sleep Insights* located at 755 Jefferson Rd, Suite 110, Rochester, NY 14623. Payment for services is accepted at The Ghaly Sleep Center or may be mailed to the above address.

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

Ghaly Sleep Center/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. Ghaly Sleep Center/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