GHALY
sleep center

6713 Collamer Rd.
East Syracuse, NY 13057
Phone: (315) 463-0421
Fax: (315) 463-0466

Thank you for scheduling a new patient consult at The Ghaly Sleep Center.

You are scheduled for _____ at _____.

* * * *ATTENTION* * * *

Currently, we are utilizing curbside check-in for all appointments. Please review and follow the steps below:

1. **In accordance with New York State, the Ghaly Sleep Center will require ALL patients or visitors entering the office to wear a face mask or face covering. Please be prepared and bring a face mask or covering with you. If you do not have one, the office will provide you a mask.**
2. **When you arrive for your appointment, please STAY IN YOUR VEHICLE and call the office at (315) 463-0421, select option 1. You will be asked a series of COVID-19 screening questions; if you answer yes to any of these questions, your appointment will need to be rescheduled.**
3. **If all answers are no, you will meet us at the office entrance for a temperature check. If your temperature is 100.4°F or higher, your appointment will need to be rescheduled.**

We also ask that patients do not bring any guests to their appointments. A parent or guardian MUST accompany a minor.

Please bring photo ID, insurance card, and COMPLETED paperwork to your appointment. Copays will be collected AT THE TIME OF SERVICE. If you are responsible for a copay and are unable to pay at the time of service, you will be asked to reschedule your appointment. Please note that **if you arrive AFTER your scheduled appointment time, you may be asked to reschedule**. If you need to cancel or reschedule your appointment, please give 24 hours notice.

If you have any questions or concerns, please contact our office at (315) 463-0421.

Thank you,
The Ghaly Sleep Center

We are conveniently located right off Route 481, in the same building as Alexander & Associates.

From the East: Take Route 298 West towards Fly Road; we are the 2nd building on the right after the 481 on-ramp.

From the North: Take Route 481 South to Exit 7, then take a right onto Route 298; we are the 2nd building on the right.

From the South: Take Route 481 North to Exit 7, then take a right onto Route 298; we are the 2nd building on the right.

From the West: Take Route 298 East past Fly Rd; we are on the left just past Dunkin Donuts.

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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: _____

_____

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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:

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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). **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** 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.

Ghaly Sleep Center / Sleep Insights Medical Associates PLLC 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.

I give my consent for **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** to use and disclose my PHI to carry out TPO. With this consent **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** 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.

Should you choose to give consent to Ghaly Sleep Center / Sleep Insights Medical Associates PLLC to speak with persons on your behalf you will need to request a written consent form to add these individuals.

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 Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC appreciate the confidence you have shown in choosing us to provide for your medical care. We are 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 commercial plans who: 1.) do not have secondary insurance or Medicaid and 2.) have not met their deductible must pay the following at time of service:***
  - $150 is due at time of service for all consultations.
  - $50 is due at time of service for all follow-up appointments.
  - $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, Ghaly Sleep Center/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 Sleep Insights Medical Associates, PLLC 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/ Sleep Insights Medical Associates, 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.

EQUIPMENT RETURN

I understand that I am responsible to return any medical equipment that was loaned to me by Ghaly Sleep Center in a timely manner. All equipment should be returned within 1-2 weeks of receipt unless otherwise specified. I will be responsible for the full price of the unit it if it is not returned. This includes home sleep testing, oximetry, actigraphy and PAP loaner machines.

AUTHORIZATION TO ASSIGN BENEFITS TO SLEEP INSIGHTS MEDICAL ASSOCIATES PLLC

I authorize my Payer(s) to pay directly to Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC any benefits due under the terms of my health care plan(s), for services provided by Sleep Insights Medical Associates PLLC. I understand Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Sleep Insights Medical Associates PLLC.

AUTHORIZATION FOR TREATMENT

I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my physician(s) or other Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physicians, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC to release all medical information as necessary to:

- All Payers* for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC entities for the purpose of providing information regarding the services and goods of Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC may not condition treatment, payment, enrollment, or eligibility for benefits on my agreeing to this provision.

I authorize Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC and my insurer(s) to share my past, current and future health, treatment and account records about services I have received from Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information held by other participating providers to provide me with better care. I authorize Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC to access any of my health information that is available in an HIE, and Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC will also make my Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC health information available through HIEs in which it participates unless I opt out. If I opt out, by checking the box below, Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC will exclude all of my Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC health information from the HIEs in which Ghaly Sleep Center/ Sleep Insights Medical Associates PLLC participates. **[ ] HIE Opt Out**

I have read, understand, and agree to the provisions of this Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Ghaly Sleep Center / Sleep Insights Medical Associates 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

*For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

SURESCRIPTS CONSENT FORM

I authorize Sleep Insights Medical Associates PLLC dba Ghaly Sleep Center to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Sleep Insights Medical Associates PLLC dba Ghaly Sleep Center providers with prescribing, assessing health conditions and recommending appropriate treatment.

I hereby opt in of providing access to any health information available in a health information exchange.

_____ _____

Signature of Patient **Date**