Hello,

Your new patient visit is scheduled on_____ at _____AM / PM at:

- ROCHESTER: 755 Jefferson Road, Suite 110, Rochester 14623 | (585) 385.6070
- GENESEO: 50 East South St, 2nd floor, Geneseo 14454 | (585) 335.4285
- DANSVILLE: Noyes Memorial Hospital, 111 Clara Barton Street, Dansville 14437 | (585) 335.4285
- OLEAN: 2676 West State Street, Suite 700 A, Olean 14760 | (716) 379.8538
- NIAGARA FALLS: 7220 Porter Rd, Niagara Falls 14304 | (716) 575.0075

Please complete the enclosed paperwork in full and mail back to our office in the enclosed stamped envelope. *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're 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.*

If you need to cancel or reschedule your appointment, kindly give 24 hours' notice, *otherwise, you will be charged a $50 no-show fee. If you are later than 10 minutes for your appointment, we will reschedule your appointment.*

Please contact our office with any questions. We look forward to helping you with your sleep care.

Thank you,
Sleep Insights

PATIENT INFORMATION

Phone: (585) 385-6070 | (716) 575.0075
SleepInsights.com

DEMOGRAPHICS

Today's date _____ Date of birth_____ Age _____ Gender _____

Last name _____ First name_____

Address _____

City _____ State _____ Zip code_____

Home phone _____ Work phone _____

Cell phone _____

Email _____ ☐ Check to enroll in Patient Portal

Preferred language: ____ English ____ Spanish ____ Other: _____

Marital status: ____ single ____ married ____divorced ____ widowed

Emergency Contact _____Phone _____

Medical Insurance Carrier: _____

Policy Holder:_____Relationship:_____

SS#:_____DOB:_____Policy Holder's Employer: _____

Policy ID#:_____Group #:_____

Primary Care Provider

Name_____ Phone _____

Address _____

If a healthcare provider or dentist referred you to Sleep Insights, please provide name:

Name_____ Is this a ____ medical provider ____ dentist?

MEDICAL & SLEEP HISTORY

Height _____ ft _____ in Weight _____ lbs

Sleep problems: ____ trouble falling and/or staying asleep ____ excessive sleepiness ____ restless legs
____snoring/breathing problems ____ abnormal behaviors in sleep

Current work status: ____ Working. If so: ____full-time ____ part-time ____ overnight shift
____ retired ____disabled
____ student ____other

Bedtime: work/school days: _____ days off/wknd: _____

Wake time: work/school days: _____ days off/wknd: _____

Do you have a regular bed partner (person or pet)? ____ yes ____ no

Have you ever been diagnosed with any of the following? Check all that apply.

- ☐ Allergies/nasal/sinusitis
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ 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)
- ☐ Insomnia
- ☐ Irregular heartbeat
- ☐ Kidney disease
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Narcolepsy
- ☐ Parkinson's disease
- ☐ PTSD (Post-traumatic stress disorder)
- ☐ Restless legs syndrome
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Surgeries: _____
- ☐ Other: _____

List current medications or attach 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 allergies and contact allergies (ex. tape, Band-Aids): _____

_____

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

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:				

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). **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.

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 **Sleep Insights Medical Associates PLLC** to use and disclose my PHI to carry out TPO. With this consent **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 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**

AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION THROUGH A HEALTH INFORMATION EXCHANGE ORGANIZATION

A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information regarding my care and treatment held by other participating providers to provide me with better care. I authorize Sleep Insights Medical Associates PLLC to access any of my health information that is available in an HIE, including health information exchange organizations HealtheConnections, Surescripts, amongst other third party health information exchange organizations, and Sleep Insights Medical Associates PLLC will also make my Sleep Insights Medical Associates PLLC health information available through HIEs in which it participates unless I opt out.

The third party health information exchange organizations share health information electronically and meet the privacy and security standards of HIPAA and New York State Law. The choice I make in this form will not affect my ability to get medical care. I also have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

If I opt out, by checking the box below, Sleep Insights Medical Associates PLLC will exclude all of my Sleep Insights Medical Associates PLLC health information from the HIEs in which Sleep Insights Medical Associates PLLC participates.

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

_____ _____

Signature of Patient **Date**

PATIENT RESPONSIBILITY AGREEMENT

The doctors and staff of 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 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, 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

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 Sleep Insights Medical Associates 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 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 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 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 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 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
- Sleep Insights Medical Associates PLLC entities for the purpose of providing information regarding the services and goods of 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. Sleep Insights Medical Associates PLLC may not condition treatment, payment, enrollment, or eligibility for benefits on my agreeing to this provision.

I authorize 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 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 regarding my care and treatment held by other participating providers to provide me with better care. I authorize Sleep Insights Medical Associates PLLC to access any of my health information that is available in an HIE, including health information exchange organizations HealtheConnections, Surescripts, amongst other third party health information exchange organizations, and Sleep Insights Medical Associates PLLC will also make my Sleep Insights Medical Associates PLLC health information available through HIEs in which it participates unless I opt out. The third-party health information exchange organizations share health information electronically and meet the privacy and security standards of HIPAA and New York State Law. The choice I make in this section will not affect my ability to get medical care. I also have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. If I opt out, by checking the box below, Sleep Insights Medical Associates PLLC will exclude all of my Sleep Insights Medical Associates PLLC health information from the HIEs in which 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. 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 to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Sleep Insights Medical Associates PLLC 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.

_____

Patient Signature **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:
Sleep Insights Medical Associates PLLC

Mailing Address of Requested Recipient:
755 Jefferson Road, Suite 110, Rochester, NY 14623

Phone Number of Recipient:
585-385-6070

Facsimile Number (Fax) of Recipient:
585-385-6071

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.