Patient Registration

PT# _____

Name_____ Date of Birth _____

Address _____ Marital Status: S M W Sep D

City_____State_____Zip_____ SS#_____

Home Phone _____ Cell Phone _____

E-mail _____ Office Phone_____

Primary Care Physician _____ Phone_____

Referring Physician_____ Phone _____

Emergency Contact

Name_____Telephone_____Relationship_____

Patient Employer Information

Employer
Name_____Phone_____

Employer Address_____City/State_____Zip_____

Patients
Occupation_____

Insured Person (If not patient)

Name_____ Date of Birth: _____ Telephone_____

Address_____City/State_____Zip_____

Relationship to Patient_____

Insurance

Medicare # (if applicable) _____

Primary Insurance Company
Name_____

ID #_____Group #_____Telephone_____

Secondary Insurance Company
Name_____

ID # _____Group#_____Telephone_____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Date_____ Signature_____

I hereby authorize SomnoTrek to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company/companies be made directly to SomnoTrek (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

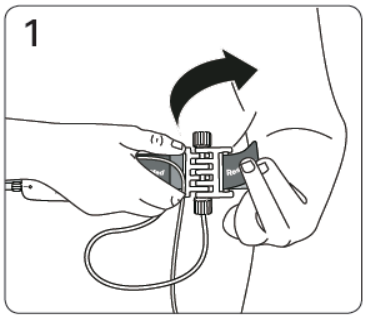
Date_____ Signature_____

(Patient, parent, or legal guardian)

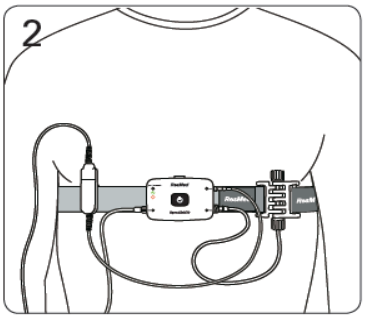
Fitting the belt

CAUTION

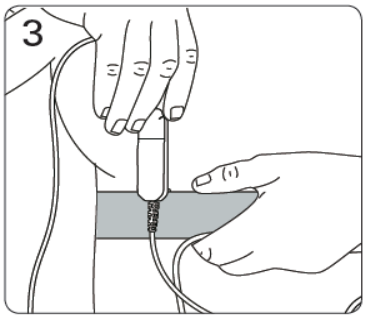
To avoid irritation or allergic reactions, wear the belt and device over a long-sleeved shirt.



1. Pull the belt around your body. Thread the end of the belt through the slot on the effort sensor (if used) and fasten the tab to the belt. If you are not using the effort sensor, attach the tab to the belt.



2. Check that the belt is secure and comfortable and that the device is positioned over the centre of your chest.



3. If using an oximeter, slide the clip onto the belt. The clip should be worn on the same side of your body as the oximeter finger sensor.

Fitting the accessories

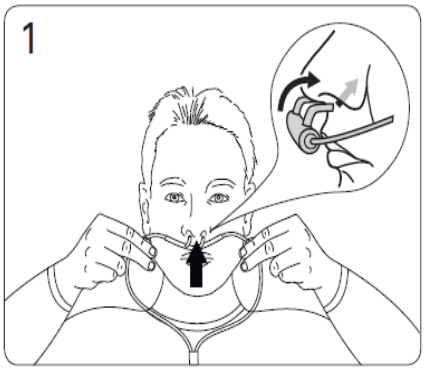
CAUTION

If you develop redness, irritation or a rash from the nasal cannula or finger sensor, discontinue use and contact your healthcare provider or physician. You may be having an allergic reaction.

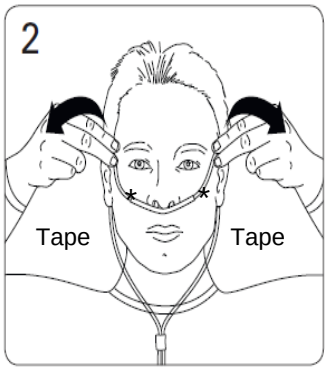
Nasal cannula

WARNING

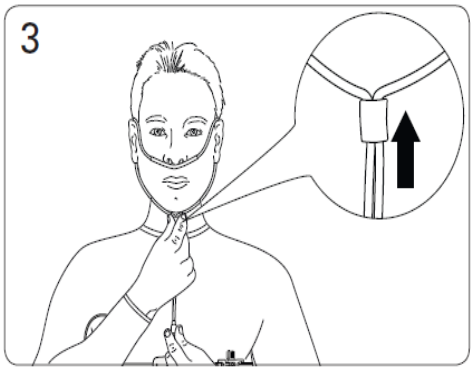
Ensure that the cannula is fitted as described so as not to pose a strangulation risk.



1. Insert the prongs into your nostrils. Make sure the curved side is pointing towards the back of your nose.



2. Loop the plastic tubing around your ears.



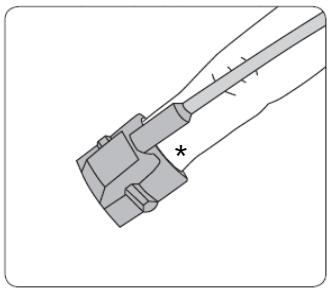
3. Pull the slider up towards your chin until the plastic tubing is secure and comfortable.

Note: If the nasal cannula does not stay in your nose, use medical tape or adhesive bandages on your cheeks to hold it in place.

Reusable finger sensor (if used)

⚠ WARNING

Ensure that the oximeter clip is positioned on the same side of the body as the finger sensor so as not to pose a strangulation risk.



Place tape around finger and probe to hold in place

1. To fit the reusable finger sensor, slip it over the index finger on your non-dominant hand as shown.

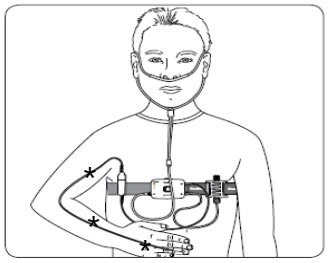
Note: If the finger sensor is uncomfortable, you can move it to a different finger or your other hand.

Press and hold button
Button turns green
Let go

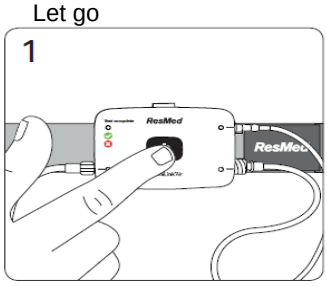
3 lights come on indicated test has started

Starting the test

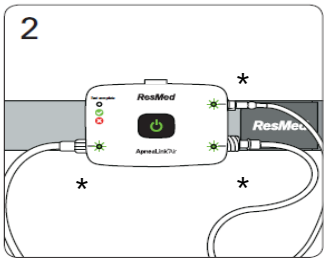
Tape



When properly set up, the full system looks like this.



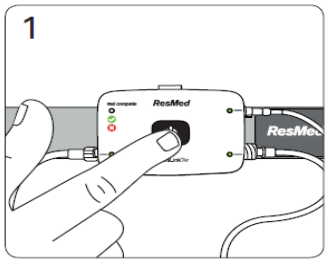
1. Press and hold the power button in the centre of the device for about three seconds or until the light turns on.



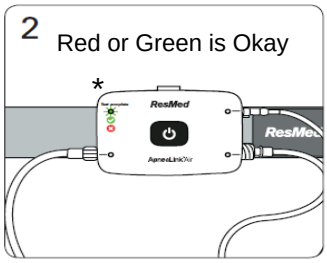
2. Check that lights next to the accessories you are using are green. If any of these lights are red and blinking, the accessories are not attached correctly.

Once you have started the test, go to sleep as normal. The lights on the device will dim after 10 minutes. If you have to get up during the night for any reason, leave the device on unless you do not intend to go back to sleep. You can remove the oximeter finger sensor if you need to go to the bathroom or wash your hands. Replace the oximeter finger sensor before going back to sleep.

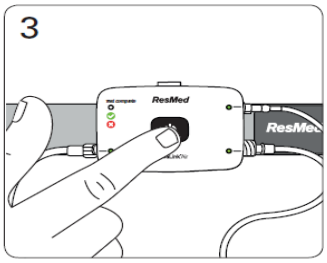
Stopping the test - check if test complete



1. Press the power button for about three seconds.



2. Check that the test complete indicator light is lit and green. This means the test is complete. If the test indicator light is red, replace the batteries and repeat the test. If the test indicator light is



3. Press and hold the power button for about three seconds to turn off the device.

If performing test for 2 night
Replace batteries (provided)
Repeat Test

I HAVE BEEN INSTRUCTED ON THE USAGE OF THE HOME SLEEP APNEA TESTING DEVICE.

Date: _____

Patient Name: _____ Signature: _____

Pennsylvania Patient Testing

Name: _____ **Date of Birth:** ____/____/ _____

Height: _____ **Age:** _____

Weight: _____ **Gender:** _____

Sleep & Medical History Questionnaire

Please complete all of the sections in this form

When did your sleep problem begin and what are you experiencing? *

Describe your sleep problem.

_____

_____

_____

_____

Have you ever had a sleep study performed? Where? Prior sleep testing.

Date: Location:

What MEDICATIONS are you currently taking? *

MEDICAL HISTORY FOR HOME SLEEP STUDY

NAME_____DATE_____

CHECK ALL THAT APPLY TO YOU

1. _____ HIGH BLOOD PRESSURE
2. _____ DIABETES
3. _____ HISTORY OF HEART ATTACK
4. _____ HISTORY OF STROKE
5. _____ HISTORY OF OTHER HEART DISEASE
6. _____ HIGH CHOLESTEROL
7. _____ GERD (REFLUX)
8. _____ THYROID PROBLEMS
9. _____ OVERWEIGHT OR TROUBLE LOSING WEIGHT
10. _____ KIDNEY PROBLEMS
11. _____ SEIZURES OR EPILEPSY
12. _____ PARKINSON'S
13. _____ CHRONIC HEADACHES
14. _____ HISTORY OF CANCER TYPE_____

15. _____ LIST YOUR HEIGHT
16. _____ LIST YOUR WEIGHT
17. _____ LIST NECK OR COLLAR SIZE (IF KNOWN)
18. _____ LIST YOUR USUAL BLOOD PRESSURE

19. COMPLETE THE ATTACHED QUESTIONNARES
    - A. THE EPWORTH SLEEPINESS SCALE AND
    - B. THE STOP-BANG SURVEY

***ALL OF THIS INFORMATION IS IMPORTANT IN INTERPRETING YOUR HOME SLEEP STUDY**

SomnoTrek

SLEEP HISTORY FOR HOME SLEEP STUDIES

NAME_____DATE_____

(CHECK ALL THAT APPLY TO YOU)

1. _____ **PREVIOUSLY DIAGNOSED SLEEP APNEA**
2. _____ **SNORING**
3. _____ **LOUD SNORING**
4. _____ **GASPING OR CHOKING DURING SLEEP (circle one or both)**
5. _____ **SOMEONE SAYING THAT YOU STOP BREATHING DURING SLEEP**
6. _____ **FREQUENT AWAKENINGS DURING SLEEP**
7. _____ **MORNING HEADACHES**
8. _____ **UNREFRESHED SLEEP**
9. _____ **FATIGUE OR SLEEPINESS WHEN AWAKE (circle one or both)**
10. _____ **DROWSY DRIVING**
11. _____ **DOZING OFF WHILE DRIVING**

12. _____ **TROUBLE FALLING ASLEEP**
13. _____ **TROUBLE STAYING ASLEEP**
14. _____ **TROUBLE FALLING BACK TO SLEEP IF YOU AWAKEN**
15. _____ **WAKING UP TOO EARLY**
16. _____ **SLEEP WALKING, NIGHT TERRORS OR NIGHTMARES (circle which applies to you)**

17. _____ **SEIZURES DURING SLEEP**
18. _____ **FREQUENT URINATION THROUGHT THE NIGHT**
19. _____ **SHIFT WORKING**
20. _____ **RESTLESS LEGS**
21. _____ **EXCESSIVE MOVEMENTS DURING SLEEP**
22. _____ **EXCESSIVE DAYTIME SLEEPINESS**
23. _____ **DAYTIME NAPPING**
24. _____ **VIVID DREAMS WHILE FALLING ASLEEP**
25. _____ **INABILITY TO MOVE FOR A BRIEF TIME ON AWAKENING**
26. _____ **WEAKNESS ESPECIALLY AFTER LAUGHING, FEAR OR EXCITEMENT...EVEN IF SUBTLE (DROPPING SOMETHING, NODDING)**

Name: _____ **Date:** _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation Chance of Dozing

Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total Score _____

STOP-BANG Sleep Apnea Questionnaire

Name _____

Height _____ Weight _____

Age _____ Male / Female _____

1. FILL OUT QUESTIONNAIRE

STOP

Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

Do you often feel **T**IRED, fatigued, or sleepy during daytime?

Yes No

Has anyone **O**BSERVED you stop breathing during your sleep?

Yes No

Do you have or are you being treated for high blood **P**RESSURE?

Yes No

BANG

BMI more than 35kg/m2?

Yes No

AGE over 50 years old?

Yes No

NECK circumference > 15.75 inches (40cm)?

Yes No

Male **G**ENDER?

Yes No

TOTAL SCORE **_____**

2. CALCULATE OSA RISK

≥ 3 yes answers: High-risk for OSA

< 3 yes answers: Low-risk for OSA

PRE-SLEEP QUESTIONNAIRE

Name: _____ Date: _____/_____/_____

1. Has today been an unusual day in any respect? Yes No

   If yes, please explain:

_____

_____

2. How much sleep did you have last night? _____ Hours

3. Did you take a nap today? Yes No If yes, how long did you nap? _____

4. Please indicate if you had alcohol, coffee, tea or soft drinks today. Specify approximate amounts and times:

Type	Amount	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Do you have any physical complaints right now? Yes No

   If yes, please explain: _____

   _____

6. Check the one statement that best describes how you feel right now:

   ____ Active and vital; alert; wide awake

   ____ Functioning at high level, but not at peak; able to concentrate

   ____ Relaxed; awake; not at full alertness; responsive

   ____ A little foggy; not at peak; let down

   ____ Foggy; beginning to lose interest in remaining awake

   ____ Sleepy; prefer to be lying down; fighting sleep; woozy

   ____ Almost in a trance; sleep onset soon; losing struggle to remain awake

8. Please indicate your desired bedtime tonight: _____

9. Please indicate at what time you will most likely wake in the morning: _____

10. Please add any additional comments you might have:

_____

_____

_____

Patient Privacy Agreement

We are required by law to protect the privacy of your medical information and to provide you with Notice describing the following:

- We may require your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for our reimbursement of care that we provide to you, and the related administrative activities supporting your treatment.
- We may be required or permitted by certain laws to use and disclose your medical information to others without your consent or authorization.
- As our patient, you have important rights regarding inspection and copying of your medical information that we maintain, amending or correcting that information, obtaining an account of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information.
- We have available Notice of Privacy Practices which fully explains your right and our obligations under the law.
- You have the right to receive a copy of our most current Notice in effect.

PLEASE LIST THOSE INDIVIDUALS WITH WHOM WE MAY COMMUNICATE AND THEIR RELATIONSHIP TO YOU.

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Patient Signature:	Date:

Guardian and/ or Caregiver Signature (Only required if patient is under the age of 18 or unable to sign) Relationship

SomnoTrek, LLC
836 Chestnut Court
Langhorne, PA 19047
P: (215) 215-370-8116 F: (215) 360-3606

HIPAA
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your Heath Record/ Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

1. Basis for planning your care and treatment.
2. Means of communication among the many health professionals who contribute to your care.
3. Legal documents describing the care you receive.
4. Means by which you or third-party payer can verify that services billed were actually provided.
5. A tool in educating health professionals.
6. A source of data for medical research.
7. A source of information for public health officials charged with improving the health of the nation.
8. A source of data for facility planning and marketing.
9. A tool with which we can assess and continually work to improve the care we render and the outcome we achieve.

Understanding what is in your record and how your health information is used helps you to:

1. Ensure its accuracy.
2. Better understand who, what, where and why other may access your heath information.
3. Make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you.

You have the right to:

1. Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522.
2. Obtain a paper copy of the notice of information practices upon request.
3. Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524.
4. Amend your health record as provided in 45CFR 164.528.
5. Obtain and accounting of disclosures of your health information as provided in 45 CFR 164.528.
6. Request Communications of your health information by alternative means or at alterative locations.
7. Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

The following, is a statement of your rights, with respect to protected health information, and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information.

This means that you may inspect and/ or obtain a copy of your protected health information contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your health care agency uses about you. Under federal law, however; you may NOT inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or protected health information that is subject to law and prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.

You have the right to request a restriction of protected health information.

You may request that as part of your protected health information not be disclosed to family members or friends who may be involved in your case or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may not request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right request to receive confidential communications from us by alternative means or at an alternative location.

We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request and explanation from you as to the basis for the request. Please make this request in writing.

You may have the right to have your physician amend your protected health information.

This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you; for facility directory, to family members or friends involved in your case, or for notification that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice electronically.

Our responsibilities:

SomnoTrek, LLC is required to:

1. Maintain the privacy of health information.
2. Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Notify you if we unable to agree to requested restriction.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us. We will NOT disclose your health information without your authorization, except as described in this notice.

FINANCIAL POLICY

The following is the terms and conditions of our Financial Policy. This policy has been designed in an effort to clear any misunderstanding that may arise regarding a patient's financial responsibility. Our main concern is that you receive the highest level of quality care and personal service. If you have any questions or concerns about our Financial Policy, please do not hesitate to contact our office and we will help you the best way we know how.

- Insurance companies and other third party payers of healthcare benefits will pay in whole or in part for the services and products ordered by your physician and provided by **SomnoTrek, LLC**. We will contact your insurance company to verify your coverage in order to provide services to you. We will bill your insurance carrier the fee for our service. SomnoTrek is NOT responsible for the completeness and accuracy of your payer's information, we therefore strongly recommend that you also contact your insurance company so that you have a clear understanding of the benefits that your plan offers you.

- Co-pays, deductibles, and co-insurance are due at the time of service, *unless other arrangements have been made*. You will be provided an estimate of charges at the time of service for ease of payment. It is understood that your final charges will depend on actual services received, which may or may not exceed our estimates. (Payment plans are available if you are not able to pay the full amount at the time of service- this is discretionary on a case by case basis)

- In some cases insurance carriers may directly send members the payments for services rendered. Payment received by your insurance carrier for services rendered by SomnoTrek, LLC must be mailed to SomnoTrek, LLC, 836 Chestnut Court, Langhorne, PA 19047. This payment will be credited toward your account.

- Appointments must be cancelled at least 24 hours before the set appointment. A fee of $50.00 may be assessed for all patients who are *not present and miss* the appointment scheduled for a visit if not cancelled within that time frame. This fee *is not* covered by your insurance. It is your responsibility to notify the office should you need to cancel.

- All returned checks will be subject to a $25.00 fee. We must emphasize that as a medical provider our relationship is with you, not your insurance company. All charges for the dates of service rendered are your responsibility. We understand that temporary financial problems may affect timely payment. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will always be willing to work with you and assist you in meeting your financial obligations.

By signing below, I acknowledge that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: _____ Date: _____

EVALUATION OF SERVICES

Dear patient,

You had a diagnostic Home Sleep Test performed by SomnoTrek. Our goal is to provide our patients with the best diagnostic sleep testing services available. Your comfort and satisfaction are extremely important to us. Please help us continue to improve upon our services by answering a few questions regarding your experience.

If you would like us to contact you regarding your comments please let us know.

1. **Were you given enough information about the home sleep test prior to your appointment?**

2. **Was your home sleep study scheduled in a timely manner?**

3. **Did the instructions provide an explanation of the testing procedure and instruct you on the use of the home sleep testing equipment?**

4. **Were you comfortable using the testing equipment?**

5. **Was our staff courteous and professional?**

6. **Please provide any additional comments or suggestions.**

_____

_____

_____

_____

Like us on Facebook https://www.facebook.com/Somnotrek/

Thank you for your feedback.
Please send this response back with your paperwork or you can print and fax your responses to 215-360-3606 or email to info@somnotrek.com

Please follow these steps for Home Sleep Apnea Testing

- Please call 215-370-8116 the day you receive the test. We want to know that you received the test promptly and answer any questions you might have.
- **Perform the Home Sleep Apnea Test on the day that you receive the unit – Do Not Delay Testing!!**
- Follow instructions on pages 2 and 3 for performing the test. If needed go to www.somnotrek.com and the Home Sleep Apnea Testing page. Scroll down for a detailed Instructional Video.
- Use medical tape provided to secure finger probe and nasal cannula.
- Complete and sign and return all paperwork required.
- Repeat the test for two nights if applicable. You will replace batteries in the back of the device (provided) for the 2nd nights test
- Unscrew and discard nasal cannula after all testing is complete.
- Place device and tape back into the bag provided – Return tape and lanyard as well.
- Place bag and paperwork in box that was mailed to you and using the pre-paid FedEx return label provided take package to an authorized FedEx location or call FedEx for pick up.
- DO NOT PUT PACKAGE IN DROP BOX
- When your test is received it will be processed and interpreted by a board certified sleep specialist
- You will be contacted with results and reports will be forwarded to your physician.