California Sleep, Inc.

1879 W. Redlands Blvd.
Redlands, CA 92373
(909) 335-5444

PATIENT INSTRUCTIONS

You have been scheduled for an overnight sleep study at California Sleep on __________ at __________p.m. It is important that you arrive on time for your appointment. Doors are kept locked, so please ring the doorbell (right side) upon arrival.

Please follow the procedures below, before your appointment:

1. Eat meals as usual. Do not consume beverages that contain alcohol or caffeine after 12:00 noon.
2. Refrain from taking naps.
3. Do not use hairspray, mousse, gel or any other hair products.
4. Do not use lotions or body oils.
5. Ladies: leave your hair natural (no extensions, no clip-ons, no weaves, no cornrows or no braids).
6. All patients: shower, wash and dry your hair (no conditioners).

What to Bring:

1. Loose-fitting, comfortable pajamas (preferably 2-pieces)
2. All medications that you usually take at bedtime
3. A list of all medications that you take on a regular basis
4. Your health insurance card and a picture ID
5. Personal hygiene items (toothbrush, comb, etc.)
6. **Important:** If you usually have a snack before bed, please bring your own food. You may use our refrigerator, if necessary.

Cancellations

In the event of a need for cancellation or rescheduling, please call the office 48 hours prior to your appointment time. Failure to do so may result in an $80.00 cancellation fee.

We thank you for your cooperation and look forward to seeing you.

NOTICE OF PRIVACY PRACTICES
CALIFORNIA SLEEP

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN ACCESS THE INFORMATION.
PLEASE READ IT CAREFULLY

The Health Insurance Portability Act of 1996 ("HIPPA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by use in any form, whether electronically, on paper, or verbally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for entities that misuse health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may disclose your medical records for each of the following:

- **Treatment:** Providing, coordinating or managing healthcare related services for one or more healthcare providers, such as a physical exam.
- **Payment:** Activities such as obtaining reimbursement for services, confirming coverage, billing or collecting procedures and utilization review.
- **Healthcare Operations:** Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifying information.

We may contact you to provide appointment reminders or treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosure of protected health information, including those related to disclosure to family members, friends, or any other person identified by you. We must abide by such restrictions unless the restriction is removed by you in writing. However, we are not required to agree to the restriction.
- The right to reasonable requests to receive confidential communication of protection of health information from us by alternative means or at alternative locations.
- The right to inspect or copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

I understand that as part of my healthcare, this organization originates and maintains healthcare records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans or care regarding future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals that contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a "Notice of Privacy Practices", which provides a more complete description of the information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and that prior to implementation, will mail a copy of the revised notice to me at the address I have previously provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or other health-related operations and that the organization is not required to agree to the restrictions requested.

I acknowledge receipt of this organizations "Notice of Privacy Practices". (Notice effective date or versions: August 30, 2011)

Signature:____________________ Printed Name:____________________ Date:____________

Financial Responsibility & Assignment of Benefits

I hereby authorize **California Sleep** to bill my health insurance carrier directly for any and all services provided to me. Furthermore, I authorize my insurance company to pay **California Sleep** directly. I understand that in the event my insurance carrier does not pay for services provided to me either in part or in full, I am ultimately responsible for payment. I also understand that I am responsible for payment of co-pays, deductibles and share-of-costs as specified by my insurance carrier.

I hereby authorize **California Sleep** to release any information necessary to secure payment from my insurance.

Signature:____________________ Date:____________

CALIFORNIA SLEEP, INC.
PATIENT INFORMATION

PERSONAL INFORMATION:

Patient Name:________________________ Birth Date:____________
Address:________________________ Social Security #____________
City & State:________________________ Zip Code:____________
Home Phone:____________ Cell Phone:____________ Work Phone:____________

Employer Name:________________________ Phone:____________
Address:________________________ Occupation:____________
City & State:________________________ Zip Code:____________

Referring Doctor:________________________ Phone:____________

Emergency Contact:

Name:________________________ Phone:____________
Address:________________________ Relationship to Patient:____________
City & State:________________________ Zip Code:____________

Responsible Party:

Name:________________________ Phone:____________
Address:________________________ Relationship to Patient:____________
City & State:________________________ Zip Code:____________

Primary Insurance:

Company Name:________________________ ID #:____________
Phone:____________ Group #:____________
Subscriber Name:________________________ Birth Date:____________

Secondary Insurance:

Company Name:________________________ ID #:____________
Phone:____________ Group #:____________
Subscriber Name:________________________ Birth Date:____________

________________________ ____________
Patient Signature **Date**

Patient Name ______________________________ **Date** ____________________

SLEEP QUESTIONNAIRE

Sleep Apnea:

1. I have been told that I snore.	YES	NO
2. I feel sleepy during the day even though I sleep through the night.	YES	NO
3. I have high blood pressure.	YES	NO
4. I have been told that I am a restless sleeper and I toss and turn a lot.	YES	NO
5. I suddenly wake up choking or gasping for breath.	YES	NO
6. I frequently wake with headaches.	YES	NO
7. I have noticed my heart pounding or beating irregularly during the night.	YES	NO
8. I am overweight and/or gaining weight.	YES	NO
9. I am sleepy or have fallen asleep while driving.	YES	NO

THE EPWORTH SLEEPINESS SCALE

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

Key:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	0	1	2	3
Sitting and reading	❍	❍	❍	❍
Watching TV	❍	❍	❍	❍
Sitting inactive in a public place (eg. theater or at a 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	❍	❍	❍	❍

Your Score: ____________

A score of 6 or above suggests excessive daytime sleepiness and should be followed up with your doctor, especially if the person concerned also fits any of the following categories:

- They appear to stop breathing during the night
- They snore (extremely loud; interestingly this is known as heroic snoring)
- They gasp or choke during the night
- They work shifts or at night
- They have fallen asleep at the wheel of a car or have nearly done so