Sleep Study Patient Intake Form

Saint Pete MRI

Account Number: SP _____

Appointment Date:	Appointment Time	Sex: Male ☐ Female ☐	Social Security Number:	Patient Birth Date:

Patient Name:	Patient Phone Number:	Interpreting Physician:
Ordering Physician:	Phone Number:	Fax Number:
Primary Care Physician:	Phone Number:	Fax Number:
Primary Insurance:	Policy / Claim Number:	Group Number:
Secondary Insurance:	Policy / Claim Number:	Group Number:

Authorization Required: ◯ Yes ◯ No	Authorization Number:	Expiration Date:
Type of Sleep Study Ordered:		

PATIENT TO COMPLETE –PLEASE PRINT LEGIBLY

Has today been an unusual day in any respect? ☐ Yes ☐ No
If so, please explain:_____

How many hours of sleep do you think you had last night? _____

Do you feel the amount of sleep you had last night was adequate? _____

Do you usually take naps during the day? ☐ Yes ☐ No
If yes, what time? _____ AM / PM How long are your naps? _____

At what time did you last eat? _____ AM / PM **Time of last caffeinated beverage:** _____ AM / PM

Write the number of beverages you drink:

Coffee, Tea, Cola: _____ Daily, _____ Weekly, Today: _____ Beer, Wine, Liquor: ____ Daily, _____Weekly, Today: _____

Do you smoke? ☐ Yes ☐ No If yes, for how long?_____
What do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Other: _____

Do you currently use oxygen at home? ☐ Yes ☐ No

Do you have any physical complaints right now? ☐ Yes ☐ No Describe: _____
Do you feel ready for bed now? ☐ Yes ☐ No

When did you last take medications to help you go to sleep or stay awake? Date: _____/_____/_____

Are you taking sleeping medications tonight? List:_____

Are you taking any other medications: _____

I attest that, to the best of my knowledge, the above information is correct. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo. I give permission for the test listed on this form to performed:

Patient Signature: **Patient Name:** **Date:**

Patient Responsibility Amount: $_____

Apt Scheduled By: _____, Date: _____Appointment Made By: _____

Epworth Sleepiness Scale

Patient Name:	Account #: SP

Please ask the patient the following questions:

Other than just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done the following activies recently, work out how they would have affected you.

0 = would **never** doze 1 = **slight** chance 2 = **moderate** chance 3 = **high** chance

Situation:	Chance of dozing	Situation:	Chance of dozing
Sitting and Reading	_____	**Watching T.V.**	_____
Sitting in a public place (e.g. theater)	_____	**As a passenger in a car for an hour**	_____
Lying down in the afternoon	_____	**Sitting and talking to someone**	_____
Sitting quietly after a lunch without alcohol	_____	**In a car stopped a few minutes in traffic**	_____

Total Score (add all responses)**:** _____

Comments: _____

Sleep Study Checklist

Patient's Name:	Appointment Date:	Appointment Time:
Type of Sleep Study Ordered:		

Patient Check-In Process:

Patient completed the New Patient Registration Packet? ☐ **Yes** ☐ **No**

Patient completed the "Patient Intake Form"? ☐ **Yes** ☐ **No**

Patient Signed Consent Form? ☐ **Yes** ☐ **No**

Patient Signed Permission to Record Audio and Video Form? ☐ **Yes** ☐ **No**

A copy of Patient's DL and Insurance Card has been placed in the chart? ☐ **Yes** ☐ **No**

Patient Co-Pay was collected (if applicable) ☐ **Yes** ☐ **No**

Sleep Study Performed by (Technician Name):	**Sleep Technician Initials:**	**Date:**	**Time:** **AM / PM**
Sleep Study Scored by (Technician Name):	**Sleep Technician Initials:**	**Date:**	**Time:** **AM / PM**
Sleep Study Scored by (Technician Name):	**Sleep Technician Initials:**	**Date:**	**Time:** **AM / PM**
Report Faxed to:	**Sleep Technician Initials:**	**Date:**	**Time:** **AM / PM**
Sleep Technician's Signature:			
Sleep Study Billed By (Employee Name):	**Employee Initials**	**Date:**	**Time:** **AM / PM**
Chart given to Dierdrick to Obtain Report: ☐ **Yes** ☐ **No**	**Employee Initials**	**Date:**	**Time:** **AM / PM**

Created on 10/11/11
Revised: 11/11/11

Patient Consent Form

Patient Name:	Account #: SP	Date:

MRI Associates of St. Pete DBA Saint Pete MRI Authorization and Agreement for Professional Services

The undersigned hereby makes the following Acknowledgement and Agreement regarding the Professional services to be provided to the patient whose name appears above.

Consent for Technical/Professional Services

I understand that services rendered are necessary for the patient by the above company and its physicians. I hereby consent to the administration of the ordered study that may be considered advisable or necessary in the judgement of the ordering physician. **I further understand that I may receive a bill for professional services if the reading physician bills for said services and that any questions I have regarding this are to be made before the study.**

Enhancement Consent

I understand that my doctor may order an image enhancement contrast to be used with my study. This contrast helps make the details of the ordered study clearer and does not mean that my condition is more serious or that there is anything additionally wrong with me. I consent to the use of enhancement only if my doctor has requested it.

Health Insurance Portability Accountability Act (HIPAA) Release of Information

I hereby give consent to SAINT PETE MRI and all healthcare providers within SAINT PETE MRI furnishing care to use and disclose my protected health information for the purpose of treatment, payment, and healthcare operations. I understand that the posted privacy policy has detailed information regarding the disclosure of my protected health information. **Furthermore, I understand that I have the right to review the posted policy before signing this consent form.** I also acknowledge that I have the right to request restrictions on the usage of my protected health information. SAINT PETE MRI is not required to grant my request. However if SAINT PETE MRI does, the restricition will be obligatory to them. Lastly, I understand that I may cancel this consent at any time but that this cancellation must be signed by me, or on my behalf, and must be delivered to SAINT PETE MRI and is only considered valid once actually received.

Direct Payment Authorization without Assignment of Benefits

By way of original or copy hereof, the undersigned patient hereby directs the applicaple personal injury or medical payments carrier to make payment directy to the above company. If payment is made out to the above company they have the authorization to endorse the payment with the patient's signature along with its own. This authorization for direct payment should not be deemed an assignment of benefits in that the patient retains all rights to enforce the applicable insurance contract and transfers no right, title, or interest in said contract, other than the right to receive direct payment as specified herein above.

Collection of Account/Agreement to Pay for Services

For and in consideration of the services provided to the above named patient, I promise to pay the above named company all charges and services rendered to or on behalf of the patient. The above company may secure any credit information that may be necessary. **I further understand that if my policy has benefit limits, and I exceed those limits, then I will be responsible for the allowed amount of the study.** I understand that if this account is assigned to an attorney, or agency, for collection/suit, the above company shall be entitled to reasonable attorney's fees and cost of collection. I understand that if any bad check is written I am only to pay by cash, money order, or credit card to redeem that check and any added incurred cost. **I understand that if a personal check is returned there will be a $75 charge as a returned check fee.**

Signature of Patient/Legal Guardian:_____ **Date:**_____

750 94th Ave N, Suite 206
St. Petersburg, FL 33702
Phone: 727.577.2220
Fax: 727.577.7230

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name:		**Account #:** SP
Date of Birth:	**Social Security #:**	**Phone #:**

Information to be released

TO:	**FROM:**
Saint Pete MRI 750 94th Ave N, Suite 206 St. Petersburg, FL 33702	

Please release the following:

☐ Problem List ☐ Lab Reports ☐ X-ray Films
☐ Progress Notes ☐ Immunizations ☐ EKG Reports
☐ History/Physical Notes ☐ X-ray Reports ☐ Other (Specify) _____

Including information (if applicable) pertaining to:

☐ Mental Health ☐ Drug/Alcohol ☐ HIV/AIDS ☐ Communicable Treatment

Purpose of Need for Disclosure:

☐ Continued Patient Care ☐ Attorney/Legal Use ☐ Disability Determination ☐ Personal Use
☐ Insurance Claim ☐ Other (Specify) _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent, in writing, at any time expect to the extent that the action has been taken in reliance on it. This consent will expire one (1) year after the date of my signature unless otherwise specified.

Signature of Patient of Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

COMPLETE BELOW SECTION ONLY IF <u>OUR</u> RECORDS ARE TO BE RELEASED DIRECTLY TO THE PATIENT:

I understand that I am requesting that my medical information be released only to myself or my legal guardian. I further understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold SAINT PETE MRI liable for any misinterpretation of the information contained in my medical record as a result of not consulting my physician.

Signature of Patient of Legal Representative: _____ **Date:** _____

Relationship to Patient: _____

Date request completed: _____ # of pages copied: _____ Intials: _____

Patient Account: SPMRI#_____

Permission to Record Audio and Video

I, _____,
Patient/Guardian Name Printed

Hereby authorize Saint Pete MRI, or their representative, to take photograph(s) and/or record audio and video

of _____.
Patient/Guardian Name Printed

I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical purposes, to assist in evaluating my sleep, or in the event of legal action. The sleep center and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

Any recordings obtained during the course of the sleep study will remain confidential, and will be considered a protected portion of your medical record.

_____ _____
Signature (patient or guardian) **Date:**

Relationship to patient if Guardian_____

_____ _____
Saint Pete MRI Witness **Date:**

Diagnostic Sleep Center

750 94th Avenue North, Suite 208
St. Petersburg, FL 33702
Phone: 727-577-2220

Patient Registration Form

Date: _____

Patient Information (Please print) **Patient Account #:_____**

Patient Information

Patient Name (Last Name, First Name, Middle Initial)		**Social Security Number**	**Age**
Present Address	**City**	**State**	**Zip Code**
Permanent Address	**City**	**State**	**Zip Code**
Patient Phone Number	**Alternative Phone Number**	**Patient Birth Date**	**Patient Sex** (circle one) ___Male ___ Female
Email Address	**Marital Status:** (Circle One) **Single Married Separated Divorced Widow**		
Spouse Name	**Spouse Phone Number**		
Guardian/Emergency Contact (Name, Address and Phone Number)			
Referring Physician Name and Address			

Insurance Information

Primary Insurance Company	**Insurance ID#**	**Group#**	
Name of Insured	**Insured Date of Birth**	**Insured Social Security**	**Relationship to Patient**
Secondary Insurance Company	**Insurance ID#**	**Group#**	
Name of Insured	**Insured Date of Birth**	**Insured Social Security**	**Relationship to Patient**

To the best of my knowledge, all information provided above is accurate and complete. I acknowledge that I am ultimately responsible for payment of my account with Saint Pete MRI.

Patient/Guardian Name (Please print) _____ Date: _____

Patient/Guardian Signature _____

Saint Pete MRI

Diagnostic Sleep Center

750 94th Avenue North, Suite 208
St. Petersburg, FL 33702
Phone: 727-577-2220

Sleep Questionnaire

Social Security Number: _____

Last Name: _____ First Name: _____ MI _____

Date of Birth: _____ Height: _____ Weight (Lbs.)_____

Phone: _____ Alt. Phone: _____

Email: _____

What is your sleep problem/complaint? Check all that apply:

☐ I have trouble falling asleep. Because? _____

_____

☐ I wake up frequently. Because? _____

_____

☐ I don't get enough sleep.
☐ I feel tired or sleepy when I shouldn't
☐ I fall asleep when I shouldn't.
☐ I snore very loudly.
☐ I stop breathing or I have been told that I stop breathing in my sleep.
☐ I do strange things while I'm sleeping such as: _____

_____

☐ I become paralyzed while falling asleep or when I sleep walk
☐ I become paralyzed when I have emotions
☐ I have unusual or vivid disturbing dreams
☐ I grind my teeth when I'm sleeping
☐ Other: _____

Do any other family members have the same or similar problems? ☐ NO ☐ YES
List all medications that you take daily or regularly; over–the-counter drugs as well as prescriptions: _____

_____

Do you smoke? ☐ NO ☐ YES, how much? _____
Do you drink alcohol? ☐ NO ☐ YES, how much? _____
Do you feel that you are currently under any unusual stress, emotional strain or depression?

☐ NO ☐YES If yes, please explain: _____

PLEASE BRING COMPLETED QUESTIONNAIRE TO YOUR SLEEP STUDY