



Integrative Insomnia & Sleep Health Center, Inc.

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CONFIDENTIAL

PATIENT CONTACT INFORMATION

First Name:	Last Name:	Mid Init.
Street Address:	Age:	DOB: / /
City:	ST:	ZIP:
Home Tel: ()	Work: ()	Cell Phone: ()
Which is the best number to reach you at?		
Fax:	Email:	

Height:	ft.	in.	Weight:	lbs.			
Marital Status:	Single	Married	Living w/ Partner	Divorced	Widowed		
Patient Race: (Optional)	Asian	Black	Cauc	Hisp	Native Amer	Pac Isl	Other:
Current Occupation:	Gender:			M	F		

Emergency Contact:	Tel: ()					
How did you hear about us?						
Referring Doctor	Friend	Internet	Radio	Newspaper	Magazine	Other:

REFERRING PHYSICIAN

Name of Referring Physician:	MD	DO	DDS	DMD	PA	NP
Street Address:						
City:	ST:	ZIP:	Specialty:			
Office Tel: ()	Office Fax: ()	Office Contact:				

PRIMARY CARE PHYSICIAN (IF DIFFERENT FROM YOUR REFERRING PHYSICIAN)

Name of Referring Physician:	MD	DO	DDS	DMD	PA	NP
Street Address:						
City:	ST:	ZIP:	Specialty:			
Office Tel: ()	Office Fax: ()	Office Contact:				

Sleep Symptoms & History

In your own words, please tell us what brings you to the sleep clinic today?

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How long have you been experiencing your sleep problems? _____ mos _____ yrs

To give us a precise understanding of your sleep problem(s), please answer the following questions to the best of your ability:

Insomnia

1. Do you have difficulty falling asleep at night?	No	Yes →	_____ nights/ wk
2. Do you have difficulty staying asleep at night?	No	Yes →	_____ nights/ wk
3. Do you wake up earlier in the morning than you prefer, unable to sleep longer?	No	Yes →	_____ nights/ wk
4. Do you wake up feeling unrefreshed in the morning?	No	Yes →	_____ nights/ wk
5. Do you feel your sleep difficulty interferes with your daytime functioning?	No	Yes →	_____ days/ wk
6. Are you able to sleep during a nap, if given the opportunity?	No	Yes	
7. Do you have a worried or overactive mind at night when you can't sleep?	No	Yes	
8. Do you currently do any shift work (evenings/overnights)?	No	Yes →	How long? _____ mos _____ yrs
9. Within the last year, has depression, anxiety or significant stress interfered with your ability to sleep?	No	Yes	
10. Do you worry about becoming physically or psychologically dependent on sleep medications?	No	Yes	N/A

Sleep Apnea & Sleepiness

11. Do you feel excessively sleepy during the day?	No	Yes →	For how long? _____ mos/yrs
12. Do you Snore? (circle)	Never	Occasionally	Frequently
			Always
			I don't know if I do
If you have a bed partner, please ask your partner to rate how loud you snore:			
1	2	3	4
5	6	7	8
9	10		
13. Have you ever been told you stop breathing in your sleep?	No	Yes	
If "yes" how often:	_____ Every night	Or	_____ Time/Wk
14. Have you experienced any weight gain over the past months or years?	No	Yes →	_____ lbs since _____ (yr)

15. Have you ever woken yourself up snorting or gasping for air?	No	Yes → _____	nights/ wk
16. Do you wake up with your heart beating rapidly or irregularly?	No	Yes → _____	nights/ wk
17. Do you wake up with a burning throat sensation or with a stomach acid taste, coughing or choking?	No	Yes → _____	nights/ wk
18. Do you wake up with a dry mouth or sore throat?	No	Yes → _____	nights/ wk
19. Do you wake up with a headache?	No	Yes → _____	nights/ wk
20. Do you often sleep 12 hours or more at a time?	No	Yes → _____	nights/ wk
21. Have you ever fallen asleep uncontrollably (like a “sleep attack”), including in inappropriate situations?	No	Yes → _____	times/ mo

Restless Legs

22. Do you experience an uncomfortable feeling in your legs with an urge to move your legs?	No	Yes → _____	nights/ wk
23. Does moving your legs give you a sense of relief from these uncomfortable feelings?	No	Yes	
24. Has your bed partner complained about you moving your legs in your sleep?	No	Yes → _____	nights/ wk

Unusual Behaviors

25. Have you ever felt sudden muscle weakness when you laughed, gotten angry, were surprised, or during sex?	No	Yes → _____	How often?
26. Have you ever been unable to move your body just as you were falling asleep or waking up?	No	Yes → _____	How often?
27. Have you ever had visual hallucinations or vivid dreams just as you were falling asleep or waking up?	No	Yes → _____	How often?
28. Do you walk in your sleep?	No	Yes → _____	How often?
29. Have you had experiences of eating in the middle of the night and not being aware of it at the time?	No	Yes → _____	How often?
30. Have you had any of these experiences while sleeping?	No	Yes → _____	How often?
			<i>Flailing Arms Kicking Legs Talking Screaming</i>
31. Do you grind or clench your teeth at night	No	Yes → _____	How often?

Tell us about your typical sleep pattern over the past month:

On Weekdays:

Bedtime:	Time of Final Awakening:	Time You Get Out of bed:
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On Weekends:

Bedtime:	Time of Final Awakening:	Time You Get Out of bed:
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On Average,

How long does it take you to fall asleep at the start of the night?	_____ min	_____ hours
How many times do you wake up?	_____	
How much total time are you awake at night?	_____ min	_____ hours

Do you have a bed partner? No Yes → Has he/she said anything about how you sleep?

Have you ever had a sleep consultation or sleep study in the past? No Yes

(Please bring in any reports you may have)

Diagnosed Sleep Disorder(s):

Is there any family history of sleep disorders? _____

Are you Currently Using or Prescribed to use CPAP/ BIPAP/APAP/ASV? _____

Consultation (year) _____ Doctor's Name: _____

Sleep Study (year) _____ Sleep Clinic Name: _____

Other treatment? _____

Lifestyle Factors

Do you currently smoke? No Yes
If "Yes," how long have you smoked? _____ Years
If "Yes," how much do you smoke in a 24-hour period? _____ Packs _____ Cigars _____ Full Pipe
Have you smoked in the past? No Yes → _____ Years
Do you drink caffeinated beverages (includes Coffee, Tea, Energy drinks, Caffeinated Soda) No Yes
If "Yes," how many (8 oz) cups of caffeinated beverages do you drink per day? _____ Glasses/ Cups/ Cans
Do you regularly drink alcohol? No Yes
If "Yes," how many drinks on week (or work) nights? _____ Beer _____ Wine _____ Shots Liquor
If "Yes," how many drinks on weekends (or holidays) _____ Beer _____ Wine _____ Shots Liquor
Do you feel depressed? Never Occasionally Frequently Always
Do you feel anxious? Never Occasionally Frequently Always
Are you currently seeing a psychiatrist, psychologist or professional counselor? No Yes
Exercise Activity: None _____ times a week How long? _____ min/workout
Type(s) of exercise: _____

Work Habits

What are your work hours?
Mon – Fri _____ am/pm to _____ am/pm Sat _____ am/pm to _____ am/pm Sun _____ am/pm to _____ am/pm

Medical History

Do you have any of the following medical conditions? (Check all that apply)

High Blood Pressure	Asthma	Depression	Parkinson's Disease
Stroke	Chronic Bronchitis	Anxiety	Alzheimer's Disease
TIA	COPD or Emphysema	Migraine Headaches	Bladder Disorder
Congestive Heart Failure	Acid Reflux (GERD)	Peripheral Neuropathy	Enlarged Prostate
Coronary Artery Disease	Rheumatoid Arthritis	Multiple Sclerosis	Diabetes (Type 1)
Atrial Fibrillation	Chronic Pain	Fibromyalgia	Diabetes (Type 2)
Other Heart Disease:	Chronic Fatigue Syndrome	PTSD:	Glaucoma
Other:	Other:	Other:	Other:

Please list any past major illnesses or surgeries:

Year

Medication Allergies or Sensitivities:

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Do you use Supplemental Oxygen? Y N

If yes, how many liters?

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What SLEEP Medications are you CURRENTLY taking? Check here if none ()

Name (prescription, over the counter, herbals)	Dosage	Frequency Per Day	Time Of Day Taken

What OTHER medications are you CURRENTLY taking? (Please use the back if necessary include over the counter & supplement?)

Name (prescription and over the counter)	Dosage	Frequency Per Day	Time Of Day Taken

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Additional medications listed on back

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in everyday situations? (Not just feeling tired, but actually dozing off or fall asleep) Even if you have not done some of the activities listed below, try to determine how they might affect you.

Use the following scale to choose the most appropriate number for the situation:

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

For each of the situations listed below, circle the number that best corresponds with your answer.

SITUATIONS	CHANCE OF DOZING OR FALLING ASLEEP
Sitting and reading	0 1 2 3
Sitting inactive in a public place (theater, meeting, etc)	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 when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in Traffic	0 1 2 3
Watching TV	0 1 2 3
ESS Total Score:	

INSURANCE INFORMATION

Patient First Name:		Last Name:		Mid Init.	
Street Address:			Age:	DOB: / /	
City:	ST:	ZIP:	SSN:		
Home Tel: ()		Work: ()		Cell Phone: ()	
Which is the best number to reach you at?					
Fax:		Email:			

Primary Insurance

First Name:		Last Name:		Mid Init.	
Insurance Carrier:			Name of Plan or Medical Group:		
ID #:	Group#:		Effective Date:		

Secondary Insurance

Insurance Carrier:			Name of Plan or Medical Group:		
ID #:	Group#:		Effective Date:		

Responsible Party

Are you the responsible party (Named Subscriber) of your insurance plan? Yes No					
If yes, skip this section			If no, please complete this section:		
Responsible party of your insurance plan:					
First Name:		Last Name:			
Relationship to Patient:		Spouse	Parent	Other:	
Address:		City:		State:	ZIP:
Home# ()		Work # ()		Cell # ()	
Employer:			Occupation:		
Address:		City:		State:	ZIP:
GENDER: M F	DATE OF BIRTH: / /		SS#		

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

In order to serve you more efficiently and to minimize the chance of any further misunderstanding, please read the following:

I hereby give authorization for payment of insurance benefits to be made directly to Integrative Insomnia and Sleep Health Center, Inc., a California Corporation. I understand that I am financially responsible for all charges, whether or not they are covered by insurance and I may be charged a fee for missed or cancelled appointments if I do not give one business day notice. I hereby authorize this healthcare provider to release all information, including psychiatric and chemical dependency, history to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I understand that I am also responsible for advising Integrative Insomnia and Sleep Health Center of any changes to my insurance, address and phone numbers on or before the date of service. If my insurance does not cover any office visit, any diagnostic testing, and/or treatment, I understand that I am responsible for full payment of services rendered and will make prompt, satisfactory arrangements to settle my account. I certify that I have read and understand the above assignment of benefits and financial agreement.

Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ hereby authorize Integrative Insomnia and Sleep Health Center to receive my medical records as needed for medical evaluation.

In addition, I authorize Integrative Insomnia and Sleep Health Center to release my medical records, to the extent necessary, to a healthcare entity involved in the treatment of sleep disorders.

A healthcare entity may include another physician whom I am seeing regarding my health, or a company, which provides appropriate medical treatment devices.

Patient's Printed Name: _____

Social Security or HIC #: _____

Signature: _____

Date: _____

(If other than patient) Name: _____

Relationship: _____

CANCELLATION AND RESCHEDULING POLICY

If you need to cancel or reschedule your appointment, we request notice AT LEAST 24 BUSINESS HOURS IN ADVANCE OF THE APPOINTMENT. We reserve dedicated time specifically for your appointment, and request the notice in order to reallocate the time to help others. Failure to receive notice at least 24 business hours in advance may result in a charge of \$25 for a follow up appointment and \$50 for a new appointment.

I have read and understand the above policy.

Signed: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

Effective February 20,2012

The privacy of your protected health information is important to us. Please review this notice carefully, as it describes how your medical information is used and maintained by our organization and by our offices and work staff. It also describes your rights as to the information and how you can get access to it.

PLEASE CONTACT US WITH ANY QUESTIONS THAT YOU MAY HAVE REGARDING THIS NOTICE. WE URGE YOU TO REVIEW THIS NOTICE CAREFULLY AND ASK ANY QUESTIONS THAT YOU MAY HAVE ABOUT THE USE OR SHARING OF YOUR PROTECTED HEALTH INFORMATION.

Your Protected Health Information

Whenever you receive or request durable medical equipment or services from our organization through a prescription, we receive and create personal medical information about you and about the equipment or services you receive or request. We need this information in order to provide equipment or services to you and to comply with certain legal requirements. It is our goal to make sure that the personal medical information we receive or create about you is kept strictly private. It is necessary, however, to use it or share this information with others from time, but only under proper circumstances.

This Notice describes how we may properly use and share your medical information, which we will refer to as "protected health information." This Notice also describes your rights to access and control your protected health information. In reviewing the Notice, it may appear that your medical information is used or shared in many ways. But, this is a comprehensive list and certain events may never occur or might happen only once or a few times. For the most part, your medical information is used or shared only in connection with the equipment or services that we provide you.

We have an obligation to make sure that we give a copy of this Notice and follow its terms. This Notice applies to protected health information generated at each of our offices.

When we refer to "we" or "us" in this Notice, we mean our organization and our staff, and also refer to each of our offices and the technicians and other work force staff who contribute to your care. We will provide you with a list of the persons and locations covered by this Notice upon your request.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

Typical Uses and Sharing:

Your protected health information may be used or disclosed for these typical situations without your prior authorization.

Treatment: We will use and disclose your protected health information in order to provide services to assist physicians or other health care providers assess your medical condition or treat you. We may disclose your protected health information to your primary care or family physician, to an Integrative Insomnia and Sleep Health Center clinician, to a specialist, or to another clinic, physician, hospital or other health care provider who requests this information in connection with your care and treatment. Your shared protected health information may include information that we receive from Integrative Insomnia and Sleep Health Center or from other physicians or health care providers. For example, we may have received and maintain an order from your physician and sleep study test results, which we may need in order to determine the durable medical equipment and services that you require. We may in turn disclose information regarding your durable medical equipment and services and other protected health information in our possession to your personal physician or other health care provider who is treating you.

Payment: We may use and disclose your protected health information in order to obtain payment for our services or to allow insurance companies, health plans, government agencies and managed care companies to process claims for services rendered by us to you. For example, we may need to give your health plan information about your health condition in order to obtain authorization for you to receive durable medical equipment or services.

Health Care Operations: We will use and disclose your protected health information in order to reevaluate the quality and appropriateness of care provided by our physicians and health care professionals. We may need to use and disclose protected health information in connection with licensing, payment certifications and other status. We may use and disclose your protected health information in our organization's day to day operations to enable it to operate smoothly, efficiently and in compliance with applicable laws. As examples, your protected health information may be used in routine activities such as calling you to remind you of a scheduled appointment. We may also consider your information in planning as well as use your information to assist in training.

Employer/Plan Sponsors: We may disclose your protected health information to your employer or other group health plan sponsor in connection with administration of the health plan and/or payment for services. Information to your employer that falls outside of these purposes may require your prior written authorization.

Healthcare Information: We may use your protect health information to contact you from time to time with information about services that we offer or coordinate your care with other health care providers or with treatment alternatives. If you do not wish to receive this type of information, you may opt out of receiving this information by contacting us. However, even if you elect not to receive this information, you may still continue to receive information made available to patients generally, such as newsletters or updates.

You, Family and Close Friends: We may disclose your protected health information to you unless there is information in your file that we are not legally authorized to release to you, such as information related to psychotherapy. We may also disclose information to a family member, friend or other person if you are incapacitated such as in a medical emergency or disaster relief. We will disclose this information only to the extent necessary to help with your health care or with payment for your health care.

Public Health and Safety Research: We may use and disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may use or disclose your protected health information for limited research purposes.

Outside Service: We may also need to share your protected health information with outside individuals or companies that perform services for us. For example, if we use a vendor or contractor to perform such things as billing or practice management, they may need access to your protected health information. We ask that any outside service or vendor safeguard the privacy of your protected health information in their possession. We do not intend to share your information with any outside service that does not need your information to do this job such as maintenance crews.

Unintended Disclosure: We will try our best to prevent this but it is possible that others may learn of protected health information because they hear or see information that is not meant for them. For example, another patient might overhear a conversation between you and a durable medical equipment or service technician. We use reasonable efforts to try to prevent any such disclosure from occurring.

Authorized Use or Disclosure:

If you specifically authorized us to do so in writing we will share your protected health information to persons who are not involved with your care and not included in one of the categories listed above. This might include, for example, your employer (for reasons other than related to health plan administration) a life insurance company or a distant relative. Our privacy Officer or our staff will provide the necessary form for this authorization. You may cancel this authorization at any time.

Unusual Uses or Disclosures

Among the unusual uses or disclosures that may occur without your prior authorization are the following:

Required by Law: We will use or disclose your protected health information when we are required to do so by law. For example, we would be required to share such information with a government agency in connection with an audit or investigation or if we are required by law to report a health condition to a federal state or local agency.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena discovery request or other lawful process.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of suspect fugitive material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

Military and Nations Security: we may disclose to Military authorities the protected health information of Armed Forces personnel. We may disclose to authorized federal officials protected health information required for lawful intelligence, counterintelligence and other national security activities.

INDIVIDUAL RIGHTS

You have rights with respect to your protected health information. If you have any questions about these rights or want to exercise any of these rights please contact us to assist you.

Inspect and Copy Your Records: Except for certain mental health information, if any is included in your records, you may inspect and receive a copy of some or all of your protected health information. Your request must be in writing and we will charge a fee to provide a copy. We also will need a reasonable time to provide the copy, as permitted by law.

Request Restrictions: You may request restrictions on how your protected health information is issued or disclosed. You can request in writing that we place additional restrictions on the use or disclosure of your protected health information. We are not required to agree to these additional restrictions but if we elect to do so, we will abide by the agreement (except in an emergency).

Receive Confidential Communications: You can specify how and where we should send protected health information. For example, you may want all such information in writing rather than left as a voice message, or you may request that we send all correspondence for you to your work address. We will accommodate reasonable requests.

Amend Your Record: If you feel that health information we have about you is incorrect or incomplete you may ask us to amend or change the information. However we might not agree to your request. There are various reasons why we may deny your request for an amendment. If you submit a request for amendment we will provide you with more information about the process. We will notify you in writing regarding our action on your request.

Log of Unusual Events: You have the right to request a log of unusual events that resulted in our sharing protected health information. We are required to maintain events on this list for six years. The log will only list those disclosures that you have not authorized and which were not related to treatment, payment or our operations. This log might include for example the sharing of information with the police or with a government agency, which was necessary without your permission.

Copy of This Notice: You may receive upon request, a paper copy of this notice at any time.

OUR RIGHT TO CHANGE NOTICE

We reserve the right to change his notice. We may modify or change our privacy practices from time to time particularly as new laws and regulations become effective. Any changes will be effective for all the protected health information that we maintain even information in existence before the change. If we materially modify our privacy practices we will provide you with a new notice advising you of these changes when you next obtain services from us.

COMPLAINTS

If you believe that your protected health information was not handled properly or feel that we have not allowed you to exercise your rights you may contact Region IX of the office of Civil Rights of the Department of Health and Human Services at (415) 437-8310 voice, (415) 437-8329 fax or at email address OCRCComplaint@hhs.gov. We respect your rights and will not retaliate against you or stop your care if you feel it necessary to file a complaint.

PLEASE SIGN THE ATTACHED ACKNOWLEDGEMENT CONFIRMING THAT YOU HAVE RECEIVED A COPY OF THIS NOTICE.

Acknowledgement of Receipt of Notice of Privacy Practices (NPP)

I hereby acknowledge that I have been provided with a copy of Integrative Insomnia and Sleep Health Center’s Notice of Privacy Practices (NPP)

Signature: _____

Date: _____

LIFETIME ASSIGNMENT OF INSURANCE BENEFITS
AND
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Medicare, Private Insurance and Medicaid Beneficiaries

Name: _____ SS#: _____

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Integrative Insomnia and Sleep Health Center Inc. for any services furnished to me by my physician or supplier.

I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services (CMS) or any agents and carriers, as well as Integrative Insomnia and Sleep Health Center Inc. any information or documentation needed to determine these benefits or the benefits payable for related services, now or in the future. I authorize Integrative Insomnia and Sleep Health Center, Inc. to release any information required to process any and all claims for reimbursement on my behalf. I permit a copy of this authorization to be used in place of the original.

I understand I am financially responsible for any charges not paid by said insurance. I agree to pay co-payments and/or deductibles designated by my insurance company or health plans, as well as non-covered services.

Services provided:

- Polysmnography / Split Night / MSLT/ Oximetry / Actigraphy
- Consultation / Office Visit
- Psychological Services
- Other: _____

Notice to Medicare Beneficiary

Medicare regulations require that we notify you when services provided or to be provided may not be covered by Medicare. Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is “Not Reasonable and Necessary” under the Medicare program standards, Medicare will deny payment for the services.

It is possible that Medicare may deny the services provide to you by Integrative Insomnia and Sleep Health Center Inc., for the following reason:

- () Non-Covered charges
- () Same or similar equipment or service billed
- () Procedure / Service not a covered Benefit with Diagnosis code billed
- () Service not covered because the patient was enrolled in a SNF / Hospice.
- () Medicare will not pay for Procedure or Service(s) that are deemed Not Medically Necessary.

Authorization to Release Medical Records to Family/ Friends or NON Medical Facilities

Name: _____ Reason: _____

Name: _____ Reason: _____