Valley Sleep Center
A Night and Day Difference!

PHONE: (480) 830-3900
FAX: (480) 830-3901
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NEW PATIENT ADULT REGISTRATION FORM

Please print and bring to your appointment if you have completed this form from our website

How did you hear about us? ☐ Doctor ☐ Patient ☐ Internet/Website ☐ **TV** ☐ Radio ☐ Other _____

Patient Information

Patient's Name: (Last) _____ (First) _____ (Middle Initial) __

Date of Birth: ___/___/___ Age: ____ Gender: ____ Marital Status: (S, M, W, D) ____

Race: White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐

Native Hawaiian/Pacific Islander ☐ Other ☐ Unreported/Refused ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Unreported/Refused ☐ Other ☐

Address: _____ City/State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email: _____

May we send you appointment reminders? Yes ☐ **No** ☐

May we contact you through email? Yes ☐ **No** ☐

Employer Name: _____ Employer Phone Number: _____

Emergency Contact Name: _____ Relationship: _____ Phone Number: (___) _____

Insurance Information

A copy of your insurance card(s) is required

Primary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: ___/___/____ ID #: _____ Group #: _____

Relationship to Patient: _____

Secondary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: ___/___/____ ID #: _____ Group #: _____

Relationship to Patient: _____

Responsible Party Information (if other than Patient)

Guarantor's Name: (Last) _____ (First) _____ (Middle Initial) ___

Date of Birth: ___/___/____ Age: ____ Gender: ____ Marital Status: (S, M, W, D) ____

Address: _____ City/State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email: _____

Employer Name: _____ Employer Phone Number: _____

I, the undersigned, certify that I, or my dependent have insurance coverage as indicated above. I assign directly to Valley Sleep Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____ _____

Patient/Parent or Legal Guardian Signature **Relationship** **Date**

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MEDICATION POLICY

Valley Sleep Center staff is **not** authorized to personally administer or assist in administration of prescription or nonprescription medication at any time. Patients can take their own medication as prescribed by their physician or have their caretaker assist them. Patients must inform their technologists of any medication taken during testing so the time and medication type can be documented for the reviewing sleep Physician.

☐ I currently **do not** take prescription or non-prescription drugs

☐ I currently take prescription and/or non-prescription drugs. Please list any prescription or non-prescription medications you take with dosage in the box below:

1. _____ **Dosage** _____ **5.** _____ **Dosage** _____

2. _____ **Dosage** _____ **6.** _____ **Dosage** _____

3. _____ **Dosage** _____ **7.** _____ **Dosage** _____

4. _____ **Dosage** _____ **8.** _____ **Dosage** _____

9. _____ **Dosage** _____ **10.** _____ **Dosage** _____

11. _____ **Dosage** _____ **12.** _____ **Dosage** _____

☐ I have **Medication allergies**. Please list medication allergies and reaction in the box below:

1. _____ **Reaction:** _____ **5.** _____ **Reaction:** _____

2. _____ **Reaction:** _____ **6.** _____ **Reaction:** _____

3. _____ **Reaction:** _____ **7.** _____ **Reaction:** _____

4. _____ **Reaction:** _____ **8.** _____ **Reaction:** _____

9. _____ **Reaction:** _____ **10.** _____ **Reaction:** _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

List any known allergies: _____

_____

Printed Name: _____ **Date**: _____

Signature: _____ **Date:** _____

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Medical History (Mark all that apply)

- ☐ No Medical History
- ☐ Acid Reflux or GERD
- ☐ Arthritis
- ☐ Cardiac Arrhythmias
- ☐ Coronary Artery Disease
- ☐ Diabetes Mellitus
- ☐ Enuresis/Urinating in Sleep
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Narcolepsy
- ☐ Obesity
- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Sleep Talking/Somnambulism
- ☐ Teeth Grinding/Bruxism
- ☐ Cancer - Type: _____
- ☐ Allergies or Allergic Rhinitis
- ☐ Asthma
- ☐ Central Sleep Apnea
- ☐ COPD
- ☐ Eating Disorder
- ☐ Excessive Daytime Sleepiness
- ☐ Heart Failure
- ☐ Hypoxemia
- ☐ Insufficient Sleep
- ☐ Memory Loss
- ☐ Nightmares
- ☐ Obstructive Sleep Apnea
- ☐ Post-Traumatic Stress Disorder
- ☐ Seizures
- ☐ Sinus Problems/Sinusitis
- ☐ Thyroid Disorder/Type: _____
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Chronic Pain
- ☐ Depression
- ☐ Enlarged Tonsils/Hypertrophy
- ☐ Head Injury
- ☐ HBP/Hypertension
- ☐ Idiopathic Hypersomnia
- ☐ Iron Deficiency
- ☐ Myocardial Infarction/Heart Attack
- ☐ Night Terrors or Night Arousals
- ☐ Palpitations
- ☐ Restless Legs Syndrome
- ☐ Shift Work Disorder
- ☐ Stroke or CVA
- ☐ Other: _____

Surgical History (Mark all that apply)

- ☐ None
- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Other-Please describe: _____
- ☐ Thyroidectomy

Family History (Mark all that apply)

- ☐ Family History Unknown
- ☐ Alcohol or Drug Abuse
- ☐ Cancer-Type: _____
- ☐ Idiopathic Hypersomnia
- ☐ Obstructive Sleep Apnea
- ☐ Night Terrors
- ☐ REM Behavior Disorder
- ☐ Sleep Talking
- ☐ No Family History to Report
- ☐ Bipolar Disorder
- ☐ Central Sleep Apnea
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Nightmares
- ☐ Restless Legs Syndrome
- ☐ Sleep walking
- ☐ Anxiety
- ☐ CAD Disease/Heart Disease
- ☐ Depression
- ☐ Loud Snoring
- ☐ Neurologic Disorder
- ☐ Periodic Limb Movements
- ☐ Sleep Related Cramps
- ☐ Stroke or CVA

☐ Other Family History: _____

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Social History

What is your marital status?

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: _____

Household members you live with:

☐ Live Alone ☐ Spouse ☐ Children ☐ Siblings ☐ Father ☐ Father-in law ☐ Mother

☐ Mother- in law ☐ Grandparents ☐ Stepfather ☐ Stepmother ☐ Foster Parents ☐ Pets ☐ Other: _____

Do you smoke? If yes, what type of product? ☐ Yes - Type: _____ ☐ No

Are you a former tobacco smoker? ☐ Yes ☐ No

Do you use tobacco products? If yes, what type? ☐ Yes - Type: _____ ☐ No

Are you a former tobacco user? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ History of alcoholism

How many times in the past year have you had 5 or more (for men) or 4 or more (for women and any adult over 65 years old) alcoholic drinks in a day? _____ **(Answer with 00 thru 365)**

Do you use or drink caffeine Products? If yes, what type and how many servings per day?

☐ Yes: Type: _____ Servings: _____ ☐ No

Do you use recreational drugs? If yes, what type?

☐ Yes: Type: _____ ☐ No

Do you use medical marijuana? If yes, what type?

☐ Yes: Type: _____ ☐ No

What is the highest level of education you have completed?

☐ Primary School ☐ Junior High ☐ High School ☐ College

☐ Graduate School ☐ Trade School

What is your work status? ☐ Employed - What is your occupation? _____ ☐ Unemployed ☐ Retired

Are you a Commercial Driver or operate heavy equipment?

☐ Yes ☐ No

Are you a Shift Worker? If so, what hours?

☐ Yes: Hours: _____ ☐ No

Are you a Pilot?

☐ Yes ☐ No

Do you have pets that sleep in your bedroom?

☐ Yes ☐ No

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Sleep History Screening Questionnaire

Chief complaint. What is the primary reason you are here today? _____

Have you had a sleep study before? ☐**Yes** ☐ **No** If yes, when? _____ Where? _____

Are you currently receiving treatment for any sleep disorder? ☐**Yes** ☐ **No** If yes, describe? _____

Current or previous CPAP or oxygen user? ☐**Yes** ☐ **No** If yes, what pressure or level do you use? _____
If yes, what number of liters of oxygen? _____

What time do you usually go to bed? ____ ☐**AM** ☐**PM** Do you have difficulty getting to sleep? ☐ **Yes** ☐ **No**

How long does it usually take you to fall asleep? _____

Have you used any medication or sleep aids to help you sleep? ☐ **Yes** ☐ **No**
If, yes what have you used? _____

How often do you usually wake up from sleep? _____ How long does it take you to go back to sleep? _____

What time do you usually wake up? ____ ☐**AM** ☐**PM** Do you feel rested when waking up? ☐ **Yes** ☐ **No**

How many hours do you sleep per day? _____

Do you frequently feel sleepy or fatigued during the hours that you are awake? ☐ **Yes** ☐ **No**

Do you frequently have the urge to take naps during your awake time? ☐ **Yes** ☐ **No**

Do you awaken from sleep with any of the following?

☐Dry mouth ☐Need to Urinate ☐Choking and gasping ☐Acid reflux or heartburn ☐Sweating ☐Panic attack

☐Fast heart rate ☐Headaches ☐Leg discomfort ☐Confusion ☐Noise ☐ Pain ☐Other: _____

Have you recently found yourself nodding off or sleeping while driving a vehicle? ☐ **Yes** ☐ **No**

Have you recently had an accident due to falling asleep or sleepiness? ☐ **Yes** ☐ **No**

Have you ever found yourself performing routine activities and/or driving without thinking? ☐ **Yes** ☐ **No**

Have you ever gone about performing a task only to find you have already done it? ☐ **Yes** ☐ **No**

Have you ever been told or suspect that you snore when you sleep? ☐ **Yes** ☐ **No**

Is your snoring heard outside of the bedroom through a closed door? ☐ **Yes** ☐ **No**

Do other people complain about your snoring? ☐ **Yes** ☐ **No**

Have you been told or suspect that you stop breathing while sleeping? ☐ **Yes** ☐ **No**

Have you ever been told or suspect that you move or thrash around frequently at night? ☐ **Yes** ☐ **No**

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Sleep History Screening Questionnaire

During strong emotions, have you ever felt physical weakness or even fallen?	☐ **Yes** ☐ **No**
Have you ever experienced vivid dream like episodes or scenes when falling asleep?	☐ **Yes** ☐ **No**
Have you ever experienced vivid dream like episodes or scenes upon awakening?	☐ **Yes** ☐ **No**
Have you ever had full body paralysis upon awakening?	☐ **Yes** ☐ **No**
Do you fall asleep while conversing without feeling sleepy?	☐ **Yes** ☐ **No**

Do you often have the urge to move your legs or have "restless legs" before sleeping?	☐ **Yes** ☐ **No**
Do you experience the urge to tap or move your legs/feet before sleeping?	☐ **Yes** ☐ **No**
Have you ever been told you kick or move every 20-40 seconds while sleeping?	☐ **Yes** ☐ **No**

Have you ever been told or suspect that you sleepwalk?	☐ **Yes** ☐ **No**
Have you ever been told or suspect that you sleep talk?	☐ **Yes** ☐ **No**
Have you ever been told or suspect that you act out your dreams?	☐ **Yes** ☐ **No**
Have you ever been told or suspect that you behave irregularly during sleep?	☐ **Yes** ☐ **No**
Have you ever been told or suspect that you kick, hit, or twitch while sleeping?	☐ **Yes** ☐ **No**
Have you ever injured yourself or other people during sleep?	☐ **Yes** ☐ **No**

Epworth Sleepiness Scale

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

0 = Would never fall asleep 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	☐**0** ☐**1** ☐**2** ☐**3**
Watching TV	☐**0** ☐**1** ☐**2** ☐**3**
Sitting in a public place (i.e., theater or a 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 when circumstances permit	☐**0** ☐**1** ☐**2** ☐**3**
Sitting and talking to someone	☐**0** ☐**1** ☐**2** ☐**3**
Sitting quietly after a lunch without alcohol	☐**0** ☐**1** ☐**2** ☐**3**
In a car, while stopped for a few minutes in traffic	☐**0** ☐**1** ☐**2** ☐**3**
Epworth Sleepiness Scale Total=	

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Functional Outcomes of Sleep Questionnaire (FOSQ)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Directions: Please put a mark in the box for your answer to each question. Select only ONE answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) **I don't do this activity for other reasons**	(4) **No Difficulty**	(3) **Yes, a little difficulty**	(2) **Yes, Moderate Difficulty**	(1) **Yes, Extreme Difficulty**
1. **Do you have difficulty concentrating on the things you do because you are sleepy or tired?**	☐	☐	☐	☐	☐
2. **Do you generally have difficulty remembering things because you are sleepy or tired?**	☐	☐	☐	☐	☐
3. **Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?**	☐	☐	☐	☐	☐
4. **Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?**	☐	☐	☐	☐	☐
5. **Do you have difficulty visiting with your family or friend in their home because you become sleep or tired?**	☐	☐	☐	☐	☐
6. **Has your relationship with family, friends, or work with family, friends, or work colleagues been affected because you are sleepy or tired?**	☐	☐	☐	☐	☐
7. **Do you have difficulty watching a movie or videotape/disc because you become sleepy or tired?**	☐	☐	☐	☐	☐
8. **Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?**	☐	☐	☐	☐	☐
9. **Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?**	☐	☐	☐	☐	☐
	(0) **I don't engage in sexual activity for other reasons**	(4) **No**	(3) **Yes, a little**	(2) **Yes, Moderately**	(1) **Yes, Extremely**
10. **Has your desire or intimacy for sex been affected because you are sleepy or tired?**	☐	☐	☐	☐	☐
Patient Name:	**DOB:**		Total Score:		

Functional Outcomes of Sleep Questionnaire (FOSQ) short

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Medical Release Form

Patient Name: _____ Date of Birth: _____

Release of Information

Initial [___] I authorize Valley Sleep Center the release of information including the diagnosis, records, examination rendered to me and claims information. Information may be released to the following people:

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____

Initial [___] *Do not release information to anyone*

The release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: ____/____/_____

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PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Valley Oximetry, Inc. as your healthcare provider. Please read and sign this form to acknowledge your understanding of our patient financial policies.

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. Patient (or patient's guardian) is responsible for payments of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Your insurance is a contract between you and your insurance company. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your coverage. This includes all primary, secondary and any tertiary coverage.
- Co pays, Coinsurance and deductibles are due at the time of service. This charge is an **estimate** of what your insurance carrier covers. Patients may incur, and are responsible for payment of any additional charges, if applicable. This includes any charges that are not covered by any secondary or tertiary insurance. We expect and encourage that you know your insurance benefits. All out of pocket amounts quoted by Valley Oximetry, Inc. are **estimates**. Prior approvals that are received from your insurance company are not a guarantee of payment.
- The patient (or patient's guardian) is required to provide a copy of their insurance card(s) and photo ID. Additionally, a Credit/Debit Card may be required to be kept on file for guarantee of payment(s), automatic payments or cancellation fees.
- A cancellation/no show fee of $100.00 will be charged if you do not notify us at least 1 business day prior to your scheduled Consultation, Follow Up appointment or your scheduled Out of Center Sleep Test. A cancelation/no show fee of $200.00 will be charged if you do not notify us at least 2 business days prior to your scheduled In Lab Sleep Study . The notification must be business days which are Monday through Friday. Please contact us at (480)830-3900 or email: sleep@valleysleepcenter.com
- The Patent (or patient's guardian) is responsible for any damage created by any service animal while the patient is in the care of Valley Sleep Center or its affiliates.
- Patient statements are sent monthly. Payments for invoices that are billed to the patient are due 30 days from receipt of billing. A $20.00 fee will apply if payments are late. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement. A service charge will apply for any payment arrangements. Any outstanding credits mays be applied towards outstanding balances. I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive autodialed, pre-recorded calls, or both, at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, pre-recorded calls, or both, and understand that my consent to such calls is not a condition of purchasing any goods or services.

I hereby assign my insurance benefits to be paid directly to Valley Oximetry, Inc. I also authorize Valley Oximetry, Inc. to release any information required to process claims or required in the course of my treatment. By signing this document, I state that all information given is accurate and true. I further acknowledge that I have read, understand and agree to the provisions of this Patient Financial Responsibility Form.

Patient/Legal Representative/Parent/Legal Guardian Signature **Date**

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NOTICE OF PRIVACY PRACTICES/HIPAA ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

Be sure to review the Notice of Privacy Practices for important information about your rights under HIPAA.

By signing below you acknowledge that the Notice of privacy practice was made available for your review, you had the opportunity to request a copy for yourself, and may view this document on our website.

_____ _____

Patient/Caretaker Signature **Date**

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PATIENT RIGHTS AND REQUIREMENTS

- A patient is treated with dignity, respect, and consideration;
- A patient is not subjected to Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse, Sexual assault, restraint or seclusion (except as allowed by ARS R9-10-1012B, Retaliation for submitting a complaint to the Department of Health Services or another entity, misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.
- A patient or patient's representative, except in an emergency, may either consent to or refuse treatment and may refuse or withdraw consent for treatment before treatment is initiated. Except in an emergency, a patient or a patient's representative is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic drug or surgical procedure.
- A patient or patient's representative is informed of the following;
  - The outpatient treatment centers policy on health care directives and the patient complaint process.
  - Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes.
  - Except as otherwise permitted by law, provides written consent to the release of information in the patient's Medical or Financial records.
- A patient has the following rights:
  - Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
  - To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
  - To receive privacy in treatment and care for personal needs.
  - To review upon written request, the patient's own medical record according to ARS 12-2293, 12-2294, and 12-2294.01.
  - To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
  - To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
  - To participate or refuse to participate in research or experimental treatment.
  - To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights
- The handling of patient complaints is generally taken care of by staff members, however, if patient complaints are above a simple fix or are not to their satisfaction these complaints should be addressed in writing to the Administrator or Director of Patient Services. Patients and staff members have the ability to inform the Administrator or Director of Patient Services to file a formal complaint or incident

SERVICES AND ACKNOWLEDGMENT OF CONSENT

I consent to Physician services included in any sleep consultation or follow up that may include but not limited to general physical examinations including ear, nose and throat; cardio/pulmonary, PAP Therapy trial and/or mask fitting, other therapy or services and gathering of general vitals. (Blood pressure, Height/Weight, neck circumference, etc.) By signing below I request that Valley Sleep Center/Physicians and its associates perform consultations and related services and sign this voluntarily to consent and authorize these procedures. I understand that if it is determined during any exam/consultation that my health requires urgent care beyond what the Sleep Center can provide, emergency services may be contacted for support. I have been given the opportunity to review and sign this consent form and I agree and understand this document.

ADVANCED DIRECTIVE

Healthcare Directives information is provided by the state of Arizona and has a system for patients to apply and store documents for healthcare provider access. Advance directives are documents that outline what healthcare and treatment decisions should be made if you are unable to communicate these wishes. Please visit https://healthcurrent.org/azhdr/ to learn more. There is no filing fee, and the process takes up to three weeks. A Healthcare Directive is not required for your visit.

Patient Name or Guardian (printed): _____ **DOB:** _____

Patient or Guardian Signature: _____ **Date:** _____