Name: _____

INFORMATION SHEET

Your sleep study will be performed at **Sleep Diagnostics of Fremont**. Our address is 556 Mowry Avenue, Suite 102, Fremont, CA 94536. Telephone: **510-742-5432**. We are located at the corner of Mowry Avenue and Cherry Lane, across the street to from Comcast Cable. Please arrive at **Sleep Diagnostics of Fremont** on _____at _____ pm. **The entrance is located in the front of the Professional Building.**

What to Expect:
The lab is equipped with individual bedrooms, each with a flat screen TV for your convenience. A bathroom is conveniently located outside the bedroom. We also have a microwave and refrigerator for late night snacks and Wi-Fi is available for any portable devices you may wish to bring. You will be asked to fill out some paperwork prior to the technologist preparing you for the sleep study. The forms in this packet will be collected at that time.

What to Bring:
1. Bring two-piece pajamas, shorts or comfortable clothing to sleep in. If you prefer to use **your own pillow**, please bring it with you **{WE RECOMMEND IT}**. You may also bring something to read, ie; magazines.
2. Please bring your own toiletries, i.e., toothbrush, comb, etc. We provide some basic toiletries, i.e. toothpaste, Q-tips, facial wipes, disposable razors, hairspray, lotion and mouthwash.
3. Please bring and take all medications as usual. **Sleep Diagnostics of Fremont** does not provide any medications, prescribed or non-prescribed. You may want to ask your physician to prescribe a sleep aide to relax you for the study.

ON THE DAY OF THE STUDY, PLEASE DO THE FOLLOWING:

Please **do not** drink any caffeine or alcohol after lunch.

Prior to your arrival, please bathe or shower, and shave. If you have a beard you do not have to shave it off.
DO NOT use any face or body moisturizers, lotions, oils, hair sprays or gel.

Please bring the following:
1. Your New Patient Paperwork (green packet)
2. Your Insurance card and Photo I.D.
3. Your referral (if your M.D. gave it directly to you)

OTHER INFORMATION:
The test will be completed at approximately 5:00-5:15 am. **You will be leaving by 6:00 am. If you are waiting for a ride please ask them to be here by 5:45 am.**

Patients with nutritional needs (diabetic, etc.) should bring necessary snacks.

****IF YOU NEED TO CANCEL OR RESCHEDULE YOUR STUDY, PLEASE CALL SLEEP DIAGNOSTICS AS SOON AS POSSIBLE AT 510-742-5432 BETWEEN THE HOURS OF 9:30am - 5:00 pm. Also, please be aware of our cancellation policy.**

IF YOU NEED TO CONTACT THE SLEEP CENTER AFTER 5:00 PM PLEASE CALL at 510.742.5432.

We look forward to seeing you at our facility!

Sleep Diagnostics of Fremont
[Fremont Sleep Apnea Center, LLC.]
556 Mowry Avenue, Suite 102
Fremont, CA 94536
(510) 742-5432

Date: July 1, 2006

RE: Cancellation and Reschedule Policy

EFFECTIVE IMMEDIATELY

As of July 1, 2006, all study patients scheduled or to be scheduled will be subject to this updated cancellation and rescheduling policy.

All cancellations and reschedules done within 72 hours of the scheduled study will be considered with no fee.

All cancellations and reschedules done within 24-48 hours of the scheduled study will be subject to a $75.00 fee.

If a cancellation or reschedule is not done and the patient is a no show to the scheduled test, a fee of $150.00 will be assessed.

These amounts will not be billed to any third party or private insurance and will be the sole responsibility of the patient scheduled to be tested. Last minute reschedules and no shows have a large financial impact to the center as it is difficult to fill a spot for a test in less then 72 hours, thus raising overhead and costs to other patients. This policy will help defer some of those costs, while allowing a continued superior patient experience, and outstanding quality of service and testing.

Thank you for your understanding.

Management

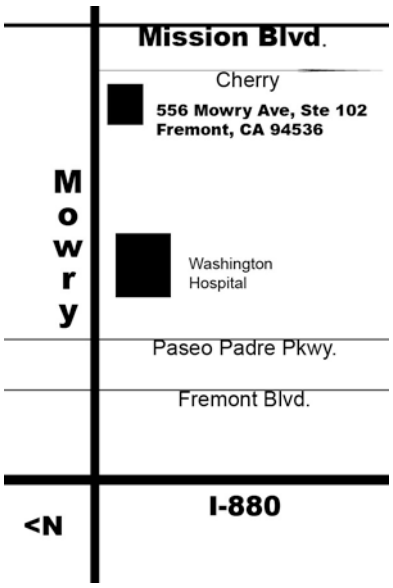
SLEEP DIAGNOSTICS OF FREMONT

556 Mowry Ave, Suite 102
Fremont, CA 94536
Direct Line: 510-742-5432

Directions to the Fremont Office

From Union City/Hayward

Take 880 South toward San Jose.
In Fremont, take the Mowry Ave. Exit.
Make a left turn (eastbound) onto Mowry.
Travel past Washington Hospital about a half mile.
On the right side you will see Mowry Medical Plaza.
We are located at the corner of Mowry and Cherry
on the right side in the two story tan building.
We are down stairs in Suite 102.



From Milpitas/San Jose

Take 880 North toward Oakland
In Fremont, take the Mowry Ave, Exit.
Make a right turn (eastbound) onto Mowry.
Travel past Washington Hospital about a half mile.
On the right side you will see Mowry Medical Plaza.
We are located at the corner of Mowry and Cherry
on the right side in the two story tan building.
We are down stairs in Suite 102.

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PATIENT REGISTRATION

Welcome to **SLEEP DIAGNOSTICS OF FREMONT.**
In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M [ ] F [ ]	Birth Date ____/____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence address City State Zip		Home Phone:	Patient's Social Security #
Person financially responsible for this account	Self [ ] Spouse[ ]	Responsible Party's Birthdate ____/____/_____	Responsible Party's Social Security #
Name of employer Address or ___ Not Applicable	Business Phone		Occupation
Reason for Visit:	Referred by: (include address and phone)		
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #
Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to **Sleep Diagnostics of Fremont** for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge and fully understand that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I have been given the opportunity to ask questions regarding my diagnosis, treatment, the procedures used, and alternatives available, if any.

I have received a copy of my Patient Rights and Responsibilities, this facility's Grievance Procedure, and have been offered information regarding Advance Directives.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

SLEEP DIAGNOSTICS OF FREMONT
INITIAL QUESTIONNAIRE

(DATE)_____

Last Name **First Name** **MI**

Address_____

Phone number **Work number** **Birth Date** **Social Security Number**

Primary Care Physician_____

Who referred you to **Sleep Diagnostics of Fremont**? _____

Medication allergies (please list)_____
Medications: Please list the medications you are now taking:
_____
_____
_____
_____

SLEEP HISTORY **_____Height** **_____Weight**

What time do you usually go to bed?_____a.m./p.m. _____p.m./a.m.

What time do you usually get up?_____a.m./p.m. _____p.m./a.m.

Do you take naps? (YES) (NO) What time? _____ How long? _____

How long have you had a sleep problem?_____weeks/months/years

How many nights per week do you have a sleep problem? _____

Do you waken during the night with the sensation of choking?_____Gasping for breath?_____

Do you wake up in the morning with a dry mouth? _____ With a sore throat? _____

On the average, how often do you wake up during the night? _____

How many times in the night do you get up to urinate? _____

Has there been any loss of short term memory? (YES) (NO) Long term memory? (YES) (NO)

Do you dream? (YES) (NO) Are you bothered by nightmares? (YES) (NO)

Do you have breathing problems at night? (YES) (NO) If yes, describe _____
_____
_____

Has anyone who has observed your sleeping commented on you having pauses in your breathing?_____

Have you been told that your legs jerk repeatedly while you are asleep? (YES) (NO)

Do you ever have an uncomfortable feeling in your legs at bedtime that is relieved only by moving your legs? (Y) (N)

Do you have sleepy spells during the day? (YES) (NO)

Have you ever had a motor vehicle accident or near-accident because of sleepiness? (YES) (NO)

Do you find it difficult to fall asleep at night? (YES) (NO)

Do you wake up in the night and then find it difficult to fall asleep again? (YES) (NO)

Are you bothered by waking too early and not being able to get back to sleep? (YES) (NO)

On the average, how long are you awake in the morning before you finally get up? _____minutes

On the average, how long do you actually sleep during the night? _____hours

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze **2 = moderate chance of dozing**

1 = slight chance of dozing **3 = great chance of dozing**

SITUATION

Sitting and reading _____

Watching television _____

Sitting inactive in a public place (theater or meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

TOTAL SCORE: _____

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:
   MEDICAL RECORDS.
   OTHER_____

2. The information will be used/disclosed for the following purpose(s):
   CONTINUANCE OF CARE.
   OTHER_____

3. Persons/organizations authorized to use or disclose the information:
   SLEEP DIAGNOSTICS OF FREMONT.

4. Persons/organizations authorized to receive the information:
   REFERRING PHYSICIAN.
   OTHER_____

5. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to deny that health care.

6. I understand that I may inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on this authorization.

8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.

9. This authorization expires on [upon] _____

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative	Relationship to patient or representative's authority to act for the patient, if applicable

A copy of this signed form will be provided to the patient.

Summary of Patient's Rights and Responsibilities

We are committed to serving you with compassion, care, skill, and respect. **Sleep Diagnostics of Fremont** does not discriminate on the basis of sex, age, creed, race or national origin. As one of our patients, you have choices, rights and responsibilities.

You have the *RIGHT*:

- to be treated with dignity and respect
- to know the names and professional status of people serving you
- to privacy
- to confidentiality of your records
- to receive accurate information about your health-related concerns
- to know the effectiveness, possible side effects and problems of all forms of treatment
- to participate in choosing a form of treatment
- to receive education and counseling
- to consent to, or refuse, any care or treatment
- to select and/or change your health care provider
- to review your medical records with a clinician
- to file a concern or grievance
- to fair and humane treatment
- to information about services and any related costs
- to self determination; including the right to make choices about life-sustaining treatment

You also have the *RESPONSIBILITY*:

- to seek medical attention promptly
- to be honest about your medical history
- to ask about anything you do not understand
- to follow health advice and medical instructions
- to report any significant changes in symptoms or failure to improve
- to respect clinic policies
- to keep appointments or cancel in advance
- to seek non-emergency care during regular business hours
- to provide useful feedback about services and policies.

_____ _____

Signature Date

Sleep Diagnostics of Fremont
556 Mowry Avenue, Suite 102
Fremont, CA 94536
510-742-5432

Sleep Diagnostics of Fremont
556 Mowry Avenue, Suite 102,
Fremont, CA 94536
510-742-5432

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.

Our facility uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our facility.

How We May Use or Disclose Your Health Information

For Treatment. We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, therapist, nurse, or other person providing health services to you, will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions take by them in the course of your treatment and note how you respond.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by law. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.522; however, our facility is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- Request that your health record be amended as provided in 45 C.F.R. §164.526;
- Request communications of your health information by alternative means or at alternative locations; and receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Concerns/Complaints

You may complain to our facility and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Managing Employee or complete and return a Patient Concern Form to our facility.

Our Obligations

Our facility is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

We reserve the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

Contact Information

If you have any questions or complaints, please contact:

Sleep Diagnostics of Fremont
556 Mowry Avenue, Suite 102,
Fremont, CA 94536
510-742-5432

ACKNOWLEDGEMENT OF RECEIPT OF
SLEEP DIAGNOSTICS OF FREMONT
NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of **Sleep Diagnostics of Fremont** Notice of Privacy Practices.

_____	_____	_____
Name (Print)	Signature	Date

Sleep Diagnostics of Fremont Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

_____

_____

_____

Concern/Grievance or Feedback Form

□ **Concern/Grievance** □ **Feedback**

If you have not been able to resolve your concern with the person directly involved, please complete this form and turn it in to either the Managing Employee or Office Manager. We will get back with you to resolve this problem within 15 days.

If this is a patient care issue that must be resolved immediately, please contact the Managing Employee in person.

Patient's Name: _____ Date: _____

Address: _____

Phone: _____Ins. Claim#: _____Carrier: _____

Person Filing Concern, if not patient: _____

Relationship to patient: _____

Reason for concern:

___ Patient Care ___ Billing ___ Other: (_____)

Have you tried to resolve this with the person/s involved? ___ yes ___ no

Describe issue:

_____

_____

_____

_____

_____

_____

Use this section to provide us with feedback to improve our services to you.

Feedback:

_____

_____

_____

_____

To be completed by facility:

Action Taken:

Issue resolved? ___ Yes (date of resolution :_____) ___ no, explain why:

_____/_____ _____

Authorized Signature Date

SLEEP DIAGNOSTICS OF FREMONT, ATTN: MANAGER
556 Mowry Avenue Suite 102, Fremont, CA 94536
510-742-5432