

## PENSACOLA SLEEP DISORDERS CENTER

Your physician has requested an all-night sleep study (polysomnogram) to evaluate your sleep. You have been scheduled for the following appointments regarding this referral. This referral may include Sleep Evaluation, Polysomnogram, Multiple Sleep Latency Test, CPAP titration and Follow-up.

The all-night sleep study (Polysomnogram) will require you to spend the night in the Center and be monitored via several small “sensors” applied to your scalp, face, chest, abdomen, and legs. The purpose of the sensors is to monitor your brain wave activity, eye movements, heart rhythm, muscle activity, and respiration.

- Please bring your insurance card(s) and drivers license with you to all appointments.
- Since the sensors will be applied to the skin and on your scalp, please bathe and shampoo your hair prior to arrival.
- Do not use any face or body moisturizer, hair spray, or gel. If wearing make-up, please remove it for the study. If wearing fingernail polish or artificial nails, it will need to be removed from one finger.
- Eat your evening meal prior to arrival for the sleep study. If diabetic, please bring a night-time snack with you. Bring and take all your medication(s) as prescribed by your doctor.
- Bring your own night-time attire. If you prefer to use your own pillow and/or blanket, you can do so.
- Wake-up time is approximately 5:00-5:30 A.M. You will be able to leave by 6:00 A.M.
- Each patient has a private room with Cable TV. We also provide shower facilities for your use.
- If you have special needs, be sure to let the staff know when scheduling your appointment.
- Billing Services provided by Panhandle Medical Services.
- **We accept checks or money orders, Visa, Master Card and Amex for your co-pays and deductibles.**
- **PLEASE LEAVE ALL VALUABLES AT HOME. PSDC DOES NOT ASSUME ANY RESPONSIBILITIES FOR LOST OR STOLEN VALUABLES BROUGHT TO THIS FACILITY**

**\*\*\*\*\*There is an administration fee for appointments that are not cancelled within 48hrs. You will be billed a fee of \$300.00 if you fail to cancel your appointment within the allotted time or fail to show for your appointment. Failure to send in payment will lead to you being sent to a collection agency.**

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# PENSACOLA SLEEP DISORDERS CENTER

Please fill out all information. This questionnaire should be brought to your first appointment at The Pensacola Sleep Disorders Center. The Questionnaire will remain a part of your Sleep Chart at the Center and usually not included in the final report. This information is vital to ensuring accurate testing and to assist in the interpretation of your results.

## General Information

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SSN:** \_\_\_\_\_ **Sex:** Male or Female **Marital Status:** Single or Married

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **Evening Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **Evening Phone:** \_\_\_\_\_

## Insurance Information

Primary Insurance Company:

Secondary Insurance Company:

\_\_\_\_\_

\_\_\_\_\_

Contract # (long # on card)

Contract # (long # on card)

\_\_\_\_\_

\_\_\_\_\_

Group # (short # on card)

Group # (short # on card)

\_\_\_\_\_

\_\_\_\_\_

Insured name as it reads on the card:

Insured name as it reads on the card:

\_\_\_\_\_

\_\_\_\_\_

## INFORMATION RELEASE/AUTHORIZATION TO TREAT

I authorize payment of medical benefits to Pensacola Sleep Disorders Center 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 that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/ or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

\_\_\_\_\_  
Patient, Parent or Guardian Signature (if child is under 18 yrs old )

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# PENSACOLA SLEEP DISORDERS CENTER

## Sleep History

What is the sleep problem you were referred for: (included when started and how long has been going on)

Have you ever been diagnosed with a sleep disorder in the past: (if yes, please give diagnosis, where seen, and treatment if it worked or not)

Check the following that has been noted by you or someone else:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> snoring                      | <input type="checkbox"/> wake up choking         | <input type="checkbox"/> vivid dreams                    |
| <input type="checkbox"/> wake up coughing             | <input type="checkbox"/> wake up short of breath | <input type="checkbox"/> start dreaming, falling asleep  |
| <input type="checkbox"/> wake up with dry mouth       | <input type="checkbox"/> wake up headache        | <input type="checkbox"/> feel very weak during day       |
| <input type="checkbox"/> wake lump in throat          | <input type="checkbox"/> sleep restlessly        | <input type="checkbox"/> sleepwalk                       |
| <input type="checkbox"/> feel tired during the day    | <input type="checkbox"/> feel sleepy all day     | <input type="checkbox"/> muscle aches during the day     |
| <input type="checkbox"/> hard time waking, A.M.       | <input type="checkbox"/> Heartburn at night      | <input type="checkbox"/> legs uncomfortable, bedtime     |
| <input type="checkbox"/> act out your dreams          | <input type="checkbox"/> feel paralyzed in bed   | <input type="checkbox"/> unable keep legs still, bedtime |
| <input type="checkbox"/> difficulty shutting mind off | <input type="checkbox"/> collapse when emotional | <input type="checkbox"/> talk in sleep                   |
| <input type="checkbox"/> leg cramps                   | <input type="checkbox"/> jerk during the night   | <input type="checkbox"/> move arms during sleep          |
| <input type="checkbox"/> wet the bed                  |  |  |

nightmares or night terrors, Do you remember them? Yes or No

Comments:

What do you believe the cause of your sleep problem is?

## Sleep Hygiene

# PENSACOLA SLEEP DISORDERS CENTER

Describe your routine on weekdays, weekends, and dayshift:

Do you work shifts: Yes or No

If yes describe:

## WEEKDAYS

How many hours of sleep are you getting a night? \_\_\_\_\_

What time do you actually get into bed? \_\_\_\_\_

Do you doze off before getting into bed? Yes or No

How long does it take to fall asleep once in bed? \_\_\_\_\_

Do you feel this is long, short, or normal? \_\_\_\_\_

How many times do you wake up during the night? \_\_\_\_\_

Do you feel this is normal? Yes or No

Why do you wake up during the night? \_\_\_\_\_

Do you have difficulty going back to sleep? \_\_\_\_\_

What time do you wake up in the morning? \_\_\_\_\_

What time do you get out of bed? \_\_\_\_\_

## WEEKENDS

How many hours of sleep are you getting a night? \_\_\_\_\_

What time do you actually get into bed? \_\_\_\_\_

Do you doze off before getting into bed? Yes or No

How long does it take to fall asleep once in bed? \_\_\_\_\_

Do you feel this is long, short, or normal? \_\_\_\_\_

How many times do you wake up during the night? \_\_\_\_\_

Do you feel this is normal? Yes or No

Why do you wake up during the night? \_\_\_\_\_

Do you have difficulty going back to sleep? \_\_\_\_\_

What time do you wake up in the morning? \_\_\_\_\_

What time do you get out of bed? \_\_\_\_\_

# PENSACOLA SLEEP DISORDERS CENTER

Do you nap or doze off during the day? Yes or No

What time of the day do you mostly feel sleepy? \_\_\_\_\_

Do you feel alert after these naps? Yes or No

Do you drink coffee? Yes or No if yes, how much: \_\_\_\_\_

Do you drink tea? Yes or No if yes, how much: \_\_\_\_\_

Do you drink soft drinks? Yes or No if yes, how much: \_\_\_\_\_

Do you eat chocolate? Yes or No if yes, how much: \_\_\_\_\_

Do you smoke tobacco? Yes or No if yes, how much: \_\_\_\_\_

Do you drink alcohol? Yes or No if yes, how much: \_\_\_\_\_

Do you exercise regularly? Yes or No

If yes how often: \_\_\_\_\_

If not, Why? \_\_\_\_\_

## **Sleep Environment**

How quiet is your bedroom? \_\_\_\_\_

How dark is your bedroom? \_\_\_\_\_

Do you have a radio, stereo, TV, on when going to sleep? Yes or No

Does it stay on all night? Yes or No

Do you eat in bed? Yes or No

Do you read in bed? Yes or No

Do you work in bed? Yes or No

Do you write in bed? Yes or No

Comments:

Are there any pets in the house? Yes or No

Do they stay in the bedroom with you? Yes or No

Comments:

Do you currently have a special bedtime routine?

# PENSACOLA SLEEP DISORDERS CENTER

## Health History

Do you have or have you had the following:

- |                          |                          |                          |                        |
|--------------------------|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | HIGH BLOOD PRESSURE      | <input type="checkbox"/> | STROKE                 |
| <input type="checkbox"/> | HEART ATTACK             | <input type="checkbox"/> | CHRONIC BACK PAIN      |
| <input type="checkbox"/> | IRREGULAR HEART BEAT     | <input type="checkbox"/> | ENLARGED PROSTATE      |
| <input type="checkbox"/> | CONGESTIVE HEART FAILURE | <input type="checkbox"/> | GLAUCOMA               |
| <input type="checkbox"/> | ANGINA OR CHEST PAINS    | <input type="checkbox"/> | ALLERGIES or HAY FEVER |
| <input type="checkbox"/> | MITRAL VALVA PROLAPSE    | <input type="checkbox"/> | DEVAITED NASAL SEPTUM  |
| <input type="checkbox"/> | COPD or EMPHYSEMA        | <input type="checkbox"/> | GOUT                   |
| <input type="checkbox"/> | ASTHMA                   | <input type="checkbox"/> | IRRITABLE BOWEL SYN    |
| <input type="checkbox"/> | DIABETES or "SUGAR"      | <input type="checkbox"/> | ACID REFLUX            |
| <input type="checkbox"/> | ARTHRITIS                | <input type="checkbox"/> | MIGRAINE HEADACHES     |
| <input type="checkbox"/> | ANXIETY                  | <input type="checkbox"/> | FIBROMYALGIA           |
| <input type="checkbox"/> | DEPRESSION               | <input type="checkbox"/> | CHRONIC FATIGUE SYN    |
| <input type="checkbox"/> | SEIZURE or EPILEPSY      | <input type="checkbox"/> | TMJ SYNDROME           |

Do you have or have you had cancer? Yes or No  
Current status?

Please list any other significant medical conditions:

Please list all surgeries you have had:

Please list all medication you are currently taking:

Patient Name: \_\_\_\_\_

# PENSACOLA SLEEP DISORDERS CENTER

What is your height? \_\_\_\_\_ Weight? \_\_\_\_\_  
Has your weight changed in the past two years? Yes or No  
If so, how much? \_\_\_\_\_ Up or Down

## Epworth Score

Rate the likelihood of you dozing off while in the following situations:

Mark the number that best represents your chance of dozing:

- 0 WOULD NEVER DOZE
- 1 SLIGHT CHANCE OF DOZING
- 2 SOME CHANCE OF DOZING
- 3 HIGH CHANCE OF DOZING

Sitting and Reading----- \_\_\_\_\_

Watching TV----- \_\_\_\_\_

Sitting inactive in a public place----- \_\_\_\_\_

Passenger in a car for an hour without a break----- \_\_\_\_\_

Lying down in the afternoon for a rest----- \_\_\_\_\_

Sitting after a lunch without alcohol----- \_\_\_\_\_

In a car, when stopped for a few minutes in traffic----- \_\_\_\_\_

**Total of all situations**----- \_\_\_\_\_

Are you currently on CPAP? Yes or No

If yes, How many years have you been wearing CPAP? \_\_\_\_\_

How many hours a night do you sleep with CPAP on? \_\_\_\_\_

How many hours do you sleep total a night? \_\_\_\_\_

Are you satisfied with your CPAP? \_\_\_\_\_

# PENSACOLA SLEEP DISORDERS CENTER

## Financial /Office Policy

Please read carefully your responsibility to our office:

1. Co-pays, deductibles, non-covered services, exclusions, and limited services are due at time of services are rendered.
2. **Patients with Medicare** who do not have a secondary insurance will be responsible for their 20%. This amount will be billed.
3. **Secondary Insurance.** We will be happy to file your secondary insurance for you.
4. **No Show Fee:** Our office will charge a fee of **\$300.00 for no show appointments. Failure to send in payment will lead to you being sent to a collection agency.**
5. **Cancellation Policy:** There is a 48 hour cancellation policy. Kindly call our office within 48 hours to cancel or reschedule your appointment. Failure to cancel within 48 hrs will result in an administration fee of \$300.00
6. **Returned Checks:** A returned check to our office will result in an insufficient funds fee of \$35.00.
7. **Change of Information:** If you have any changes in your insurance coverage, name change, etc. it is your responsibility to let us know immediately.
8. **Insurance denials/holds:** If your insurance denies, holds, etc. a claim, you will be responsible for the bill.
9. **Leave valuables at home:** Pensacola Sleep Disorders Center does not assume liability if you bring something of value (ie: jewelry, money, electronics, etc.) to your sleep study and these item are lost or stolen.

## 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 THIS CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

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## OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice takes effect January 1, 2005 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies, please contact us using the information listed at the end of this notice.

# PENSACOLA SLEEP DISORDERS CENTER

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## Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Uses and Disclosures Based On Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

**Others Involved in Your Health Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

**Public Health and Safety:** We may 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 disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health purposes.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Required by Law:** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

**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, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

**Law Enforcement:** We may disclose limited information to law enforcement officials concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

# PENSACOLA SLEEP DISORDERS CENTER

## Patient Rights

**Access:** You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter.

**Restriction Requests:** You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

**Confidential Communication:** You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continue to permit us to bill and collect payment from you.

**Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reason. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name of the amendment and to include the changes in any future disclosures of that information.

## Filing a Complaint of Concern

If you experience a problem with a member of our staff or have difficulty using our services, there are several courses of action you may elect to take.

- If the problem is related to your healthcare, please attempt to discuss your concerns with the healthcare practitioner with whom you have been working with. You may also request to be referred to the staff member's supervisor.
- There may be times when a problem should be brought directly to the attention of the Administrator of Compliance Officer. This can be done verbally or in writing. If this type involves medical care you received while a patient here, the Administrator will want to review your medical record and any other documentation you may want to provide to clarify the matter.
- Some serious concerns may be referred to and resolved by the Medical Director of the clinic, who functions in advisory role to the clinic staff.
- The ultimate decision for a concern of complaint that cannot be resolved within the scope of the areas previously mentioned will be determined by the Governing Body of the Clinic.
- In addition, we are always interested in your feedback. Please feel free to give us a verbal or written recommendation.

Regardless of how you share your concern or complaint about your experience at The Pensacola Sleep Disorders Center, you are entitled to a review of, and response to your concerns. We are committed to investigating and responding to any issues related to our facilities and will make every reasonable effort to resolve any problems you may experience, and improve deficiencies where possible. Any questions concerning this policy should be directed to the Clinic Administrator.

# PENSACOLA SLEEP DISORDERS CENTER

## CONSENT FOR SPECIAL PROCEDURE

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

I, \_\_\_\_\_ authorize the performance of a sleep recording to be performed.

I am responsible for bringing and taking my prescribed medication myself. I authorize the performance of a sleep recording ordered by the physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of the procedure. The nature and purpose of the procedure has been fully explained to me. I understand the room is adapted for the sleep center and the bedroom environment is necessary to simulate, as near as possible a real life situation. **I understand that in the event of an emergency, 911 will be activated.** I authorize the taking of pictures and videotaping with soundtrack during my polysomnogram as part of the diagnostic procedure. This is an observational tool only and will be kept in the strictest confidence.

**I authorize payment of medical benefits** to Pensacola Sleep Disorders Center for any services rendered. 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 agents 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. **My insurance will be billed separately for the sleep study interpretation, which is a service provided to me for diagnosis and recommended treatment by a Sleep Specialist Physician.** Your Sleep test will be interpreted by: Dr. Jack Obeid, F.C.C.P./ Critical care medicine and Sleep Disorders.

I acknowledge that I received a copy of Pensacola Sleep Disorder Centers' **Notice of Privacy Practices.**

\_\_\_\_\_  
Patient or Responsible Party

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

# PENSACOLA SLEEP DISORDERS CENTER

## Authorization for Release of Information

I, \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ currently living at  
\_\_\_\_\_  
Street Address City State Zip

Authorize the following PHI (personal health information) for disclosure:

Abstract/Pertinent information       Sleep Study Results       Doctor's H & P Notes  
 Physician orders       Patient information sheet       Insurance information

The above information is disclosed for the following purposes:

Medical Care/ To continue medical care/ Referrals       Legal       Insurance       Billing

**READ CAREFULLY:** I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency that requested my PHI to continue my medical care. Drug and alcohol abuse information records are specifically protected by federal regulations and by signing this authorization I am allowing the release of any drug, alcohol and/or psychiatric information records to the agency or person requesting my medical records. I understand that my records may contain information regarding the diagnosis and treatment of HIV (AIDS virus) and other sexually transmitted diseases and by signing this authorization, I am allowing this information to be released to the agency or person requesting my PHI. I also understand that I may revoke this authorization at any time by written request from myself or my family, except to the extent that action has already been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subjected to re-disclosure by the recipient and no longer protected.

This consent shall remain in effect until I revoke it.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this consent.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(If signed by personal representative, state relationship/authority to do so.)

### THE FOLLOWING APPLIES ONLY TO DRUG/ALCOHOL ABUSE OR TREATMENT INFORMATION RECORDS:

**Prohibition on Redisclosure:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation 472-CFR-2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

# PENSACOLA SLEEP DISORDERS CENTER

## **Acknowledgment of Receipt of Notice of Privacy, Practices, Office Policies, Patient Rights and Responsibilities, and Financial Policy**

I acknowledge that I was provided a copy of Office Privacy Practices and Office Financial Policies and have received (or had the opportunity to read if I so chose to). I understand the notices provided and my financial responsibilities to The Pensacola Sleep Disorders Center.

\_\_\_\_\_  
Patient Name (Print Please)

\_\_\_\_\_  
Signature/Patient, Parent, of Guardian

\_\_\_\_\_  
Date

# PENSACOLA SLEEP DISORDERS CENTER

## Medicare Part B Determination of Primary Insurance

Medicare wants to know which **ONE** statement is true for **YOU**

I am **OVER** 65, married and:

- |   |                                     |
|---|-------------------------------------|
| 1) My spouse and I are both fully retired.  | Medicare is <b>Primary</b> from me  |
| 2) I work full or part-time (my spouse is retired) for a company with:<br>(a) LESS than 20 employees  | Medicare is <b>Primary</b> from me  |
| (b) MORE than 20 employees  | Medicare is <b>Secondary</b> for me |
| 3) My spouse works full or part-time (I am retired) for a company with:<br>(a) LESS than 20 employees | Medicare is <b>Primary</b> from me  |
| (b) MORE than 20 employees  | Medicare is <b>Secondary</b> for me |

I am **OVER** 65, not married (includes widowed) and:

- |   |                                     |
|---|-------------------------------------|
| 4) I am fully retired   | Medicare is <b>Primary</b> from me  |
| 5) I work full or part-time for a company with:<br>(a) LESS than 20 employees | Medicare is <b>Primary</b> from me  |
| (b) MORE than 20 employees  | Medicare is <b>Secondary</b> for me |

I am **UNDER** 65, **DISABLED** and:

- 6) I (have/do not have) health care coverage through a LGHP with and employer who has 100 or more employees.
- 7) I (have/do not have) health care coverage through anyone else.

### Check any Additional Conditions:

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> I have End Stage Renal Disease.           | Medicare is <b>Secondary</b> for me |
| <input type="checkbox"/> I am entitled to Black Lung Benefits.     | Medicare is <b>Secondary</b> for me |
| <input type="checkbox"/> I am entitled to Veteran's Adm. Benefits. | Medicare is <b>Secondary</b> for me |
| <input type="checkbox"/> COBRA Benefits apply.                     | Medicare is <b>Secondary</b> for me |
| <input type="checkbox"/> I was injured in an accident.             | Medicare is <b>Secondary</b> for me |
| Type of Accident: _____  |                                     |
| Date of Accident: _____  |                                     |
| Description: _____   |                                     |
| _____  |                                     |
| _____  |                                     |

**If none of the above describes your situation, please explain:**

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# PENSACOLA SLEEP DISORDERS CENTER

Print Name of Beneficiary/Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Beneficiary/Patient \_\_\_\_\_

**Patient Name** \_\_\_\_\_

**Medicare Number** \_\_\_\_\_

Instructions: Please read this form carefully, check applicable spaces, and sign.

Insurance Authorization-Patient Release and Authorization:

\_\_\_\_ I hereby give lifetime authorization for payment of insurance benefits made directly to Pensacola Sleep Disorders Center and any assisting physicians, for services rendered, I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection and reasonable attorneys fees. I further agree that a photocopy of this agreement shall be as valid as the original.

\_\_\_\_ I further authorize the release of any medical information required by my insurance carrier(s)

\_\_\_\_ I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

Medicare Authorization-Patient Release and Authorization

\_\_\_\_ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

\_\_\_\_ I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

**Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.**

Medicare Acknowledgment – Rehabilitation Services Billing and Reimbursement

\_\_\_\_ I am aware that Medicare and/or Insurance will not reimburse some costs of my Rehabilitation.

\_\_\_\_ I am aware that Medicare Law requires Pensacola Sleep Disorders Center to make me aware that I will be billed for these non-reimbursable services.

\_\_\_\_ I am aware that these procedures are integral to my rehabilitation and cannot be eliminated; therefore, I may expect to be billed for any difference between the final bill and the allowable charges.

PLEASE CONTACT THIS OFFICE FOR FINANCIAL ARRANGEMENTS.

\_\_\_\_ I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING ANY AND ALL CHARGES INCURRED IN THE REHABILITATION PROGRAM NOT REIMBURSED.

WITNESS \_\_\_\_\_

PATIENT \_\_\_\_\_ Date \_\_\_\_\_