Patient Registration

PATIENT INFORMATION

Patient Name | Email Address | Date of Birth | SSN

Mailing Address | Gender | Marital Status

☐ I agree to accept text messages to this number from Focus Sleep

Phone Number | Best Time to Contact | Requested Sleep Clinic

Parent or Guardian Name | Parent or Guardian Phone Number | Relationship to Patient

Emergency Contact Name | *Same as above* ☐ | Emergency Contact Phone Number | Relationship to Patient

Referring Physician's Name | Referring Physician's Phone Number | Referring Physician's Office Location (City, ST)

PRIMARY INSURANCE

Provider Name | Provider Phone Number

Provider Mailing Address

Subscriber's Name | Subscriber's Relationship to Patient | Subscriber's DOB | Subscriber's SSN

Group Number | Policy Number | Effective Date

SECONDARY INSURANCE

Provider Name | Provider Phone Number

Provider Mailing Address

Subscriber's Name | Subscriber's Relationship to Patient | Subscriber's DOB | Subscriber's SSN

Group Number | Policy Number | Effective Date

Authorization to Release Medical Information, Claim Payments, and Insurance Verifications

☐ *My initials signify that I authorize the Focus Sleep Centers to furnish any information and records regarding the services provided to me, including information regarding psychiatric, substance abuse and communicable disease as follows: a) to any person or corporation I indicate is responsible for paying my healthcare bills or may be liable under a contract with me to pay my healthcare bills; b) to any healthcare providers to have access to my healthcare records as needed for the purposes of continuity of care.*

☐ *I hereby authorize the Focus Sleep Centers to release any information regarding services rendered by them; and to allow a photocopy of my signature to be used to file my Medicare and/or insurance claim, and any third-party payor.*

☐ *I hereby authorize the Focus Sleep Centers to bill my insurance carrier and receive payment(s) directly for service on my behalf. By signing below, I am verifying the personal data on this sheet is accurate and indicating I understand the information provided.*

Patient Signature* (or authorized representative if patient is under 18 years old) | Date

**Your typed signature will serve in lieu of a handwritten signature*

6858 Swinnea Road
1A&B Rutland Place
Southaven, Mississippi 38671

Phone (662) 349-9802
Fax (662) 349-9810

7730 Wolf River Boulevard
Suite 106
Germantown, Tennessee 38138

Phone (901) 405-1023
Fax (901) 614-8937

Patient Registration

FINANCIAL POLICY

The Focus Sleep Centers (ASC) believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We accept credit cards and debit cards. For testing and/or equipment, you may use Care Credit or speak to one of our representatives about a payment plan. We do not keep cash on site and therefore cannot make change or accept cash payment. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. If you are unable to meet this obligation at the time of service, you must make payment arrangements prior to receiving service and/or supplies. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are participating providers with many insurance plans. We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

If you are insured by a plan with which we have no prior arrangement, we will still prepare and send the claim in for you. If you receive payment for a service or supply furnished by our office, you are expected to make payment to Focus Sleep Centers immediately.

Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

3. MEDICAL RECORDS We charge $20 for pages 1-20 and $1 per page for the next eighty (80) pages, and 50¢ per page for all pages thereafter. Ten percent (10%) of the total charge may be added for postage and handling. There is no charge to patients for their first copy.

4. RETURNED CHECKS We typically do not accept checks, but if you are approved to pay in check form, any returned checks will incur a $30.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving any further services or supplies from the Focus Sleep Centers. Stop payments constitute a breach of payment and are subject to the $30.00 service fee and collections action.

5. MISSED APPOINTMENTS OR LATE NOTICE OF CANCELATION If you find you will be unable to keep any appointment or test with us, please let us know two business days prior to your appointment. We have staff specifically scheduled for your appointments and testing, and failure to comply with this policy may result in charges added to your account as follows: $50 office visit or device setup appointment, $100 home sleep study appointment, $50 per day of HST device not returned on time, and $200 in-lab sleep study appointment.

6. ACCOUNTING PRINCIPLES Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. BILLING OFFICE If you have questions regarding any of your billing statements, our accounts receivable staff is available to assist you. Call our billing department at 866-775-8150.

8. RESPONSIBILITY FOR PAYMENT You understand that you, personally, are financially responsible to Focus Sleep Centers for charges not covered by the assignment of insurance benefits.

9. DME SUPPLY LIMITATIONS You understand that if you have benefits through a federally funded insurance plan, and Focus Sleep Centers provided and billed for a sleep study on your behalf, then Focus Sleep Centers is not authorized to provide Durable Medical Equipment to you. These insurances include Medicare, Medicaid, TRICARE, and the Veterans Administration. If you are eligible for the above stated benefits, Focus Sleep Centers will assist you in locating a supplier who can meet your Durable Medical Equipment needs. You must notify Focus Sleep Centers in writing immediately if you become eligible for one of these payers.

10. INTERPRETATION FEES You understand that Sleep Studies performed by Focus Sleep Centers are interpreted by a qualified Sleep Medicine Specialist. You may receive a separate billing for this service. Payment should be made directly to the interpreting physician for this service.

Your signature below confirms that you understand the above Financial Policy and agree to abide by its terms. The signing of this Financial Policy is a prerequisite to receiving any service or supply from the Focus Sleep Centers.

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PROTECTED HEALTH INFORMATION DISCLOSURE

Acknowledgement

The department of Health and Human Services has established a "Privacy Act" to help ensure that personal health care information is protected for privacy. The Privacy Act was also created to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient and/or 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 responsible precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel require access to your health care information and information about treatment, payment, or health care operations to provide services that are in your best interest.

I acknowledge that I have received, or had the opportunity to receive, a full copy of my full rights regarding my personal health information. I understand that I can obtain an additional copy of these rights from this office or on the Focus Sleep Centers website (www.focussleepcenters.com) at any time.

I have reviewed and understand my rights regarding my personal healthcare information.

Patient Name

Patient Signature* (or authorized representative if patient is under 18 years old) **Date**

****Your typed signature will serve in lieu of a handwritten signature***

Disclosure

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule gives individuals the right to request a restriction on uses of Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's home, work, or fax number.

The Privacy Rule requires healthcare providers to take reasonable steps to limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

Use and disclosure for Treatment, Payment and Operations may be permitted without prior consent and in emergency situations.

Communication of my Protected Health Information may be handled in the following manner (check all that you agree to):

- ☐ Provider may mail information to my home address
- ☐ Provider may mail information to my work address
- ☐ Provider may leave information on my telephone
  (This may include appointment reminders or information regarding visit or study results)
- ☐ Provider may send information to my fax number
- ☐ Provider may exchange information via my email address
- ☐ Provider may share information with

Name Relationship Contact Information

Patient Signature* (or authorized representative if patient is under 18 years old) **Date**

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INFORMATION AND PATIENT RELEASES

My initials below indicate my consent to and/or acknowledge the information presented.

☐ In order to collect a complete and detailed sleep study that will enable the physician(s) providing my care to effectively diagnose and treat my sleep condition, I, the undersigned, consent and authorize photographic, video, and/or audio data to be recorded during the testing procedure.

☐ I further authorize the subsequent use of my photographic, video, and/or audio recording to be used for the furtherance of medical science and/or for medical education purposes. I consent to the presentation of all relevant medical information and clinical demonstration concerning my/this case to students of medicine and allied health sciences, to medical professional groups, and to the possible publication thereof in scientific literature. Anonymity will be ensured.

☐ I understand that Focus Sleep Center employees sleep tech trainees who have completed an accredited classroom program. Trainees always work under direct supervision and training of registered and/or certified polysomnographic technicians. Their name badge will identify them as a trainee and will never be left alone in charge of my care.

☐ Sleepiness causes auto crashes because it impairs your reaction time and attention and ultimately can lead to you falling asleep at the wheel.

☐ Although no driver is immune to drowsy driving-related accidents, there are higher risks to some populations. People with untreated sleep apnea, narcolepsy or other sleep disorders are at higher risk for driving-related accidents.

☐ Upon completion of a physician directed sleep disorders test performed at Focus Sleep Centers you have been provided written explanation of the consequences and are hereby advised against driving until such time as you have been evaluated, diagnosed, and successfully treated by a physician for any sleep disorder that can impair your ability to safely operate a motor vehicle, and until such time as all symptoms of excessive sleepiness have been successfully resolved.

My signature below confirms I have read and understand the above paragraphs.

Patient Name _____

Patient Signature* **(or authorized representative if patient is under 18 years old)** _____ **Date** _____

Your typed signature will serve in lieu of a handwritten signature

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Patient Registration

PATIENT QUESTIONNAIRE

Patient Name **Date**

Age **Height** **Weight** **Marital Status** **Referring Physician**

Occupation

Reason for this study (in your own words)

Sleep Schedule

		Weekdays	Weekends
1	What time do you typically go to bed?		
2	What time do you typically wake up?		
3	What time do you typically go to work?		
4	What time do you typically get off work?		
5	On average, how many hours of sleep do you get per night?		
6	Do you feel you get too much or too little sleep at night?		

Nighttime Symptoms

7	How long does it typically take you to fall asleep?	Mintues
8	Do you have thoughts that prevent sleep?	
9	Do you have trouble getting to sleep at night?	
10	Do you awaken at night to use the bathroom? If yes, how frequently?	
11	Are you ever awakened by a "coughing spell" during the night?	
12	Do you have a crawling sensation in your legs when falling asleep?	
13	Do you have twitching movements in your legs during the night?	
14	Do you awaken with racing thoughts, sadness, or anxiety?	
15	Have other people told you that you have restless sleep?	
16	If you awaken, do you have trouble going back to sleep during the night?	
17	Has anyone ever told you, you snore badly?	
18	Do you have difficulty breathing at night?	
19	Do you awaken with headaches? If yes, how frequently?	
20	Do you awaken with a sour or bitter taste in your mouth? If yes, how frequently?	
21	Is it difficult for you to awaken & get out of bed after sleeping? If yes, how often?	
22	Have you ever experienced paralysis upon awakening from sleep? If yes, how frequently?	
23	Do you ever have vivid dreams as you are falling asleep? If yes, how frequently?	
24	Is your sleep disturbed by a medical problem?	

If so, please elaborate:

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updated Aug. 2024

FOCUS sleep centers

Patient Registration

PATIENT QUESTIONNAIRE (CONTINUED)

Daytime Symptoms

25 Do you deliberately take naps during the day? .....

26 Do you feel rested or refreshed after a nap? .....

27 Are you bothered by sleepiness during the day? If yes, how often? .....

28 Do you find yourself falling asleep unintentionally? If yes, how often? .....

29 On average, how many times per week do you take naps during the day? .....

30 Have you or anyone else noticed any changes in your personality recently, such as:

- ☐ *irritability*
- ☐ *anxiety*
- ☐ *depression*
- ☐ *loss of concentration*
- ☐ *feeling "spaced out"*
- ☐ *poor memory*
- ☐ *increased temper*
- ☐ *decreased job productivity*

31 Have you ever experienced the following suddenly during an emotional situation?
(For example: when laughing, if angry, in an exciting situation, etc.)

	Never	One to five times in your life	Monthly	Weekly	Daily Almost Daily
Knees bucking					
Mouth opening					
Head nodding					
Falling down					

32 Have you or has anyone else noticed you:

	Age Started	Last Occurred	Frequency	Treatment
Talk while asleep				
Sleepwalk				
Grit teeth while asleep				
Wake screaming, anxious or afraid				
Have nightmares				
Move unusually while asleep				

33 If anyone in your family has or had sleep problems, please list their relationship and the issue:

Patient Registration

PATIENT QUESTIONNAIRE (CONTINUED)

Health History

34 Please select all that apply

- ☐ Anxiety
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Colitis
- ☐ Dementia
- ☐ Depression
- ☐ Deviated Nasal Septum
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Lung Disease
- ☐ Narcolepsy
- ☐ Neurologic Disease
- ☐ Parkinson's Disease
- ☐ Psychiatric
- ☐ Sinus Problems
- ☐ Sinus Surgery
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tonsillectomy
- ☐ Weight Problems
- ☐ Ulcers

35 Please list any other health concerns or surgical history:

36 How many cups do you consume daily? Coffee Tea (Hot or Iced) Caffeinated Drinks

37 Do you smoke? How many years? How many packs per day?

38 Do you drink alcoholic beverages? How many drinks?

Medications

39 Please list any medications below and **bring** all bottles of medication to each appointment:

Medication	Dosage	Frequency	Years Taken	Reason for Taking

40 Please describe any other issues / aspects you feel are important

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FOCUS sleep centers

Patient Registration

RELEASE OF INFORMATION CONSENT FORM

Check either or both boxes:

☐ I authorize Focus Sleep Centers to RELEASE medical records information to the below listed parties:

☐ I authorize Focus Sleep Centers to OBTAIN medical records information from the below listed parties:

_____

Initials in the blanks below indicate your understanding and agreement:

_____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked it shall terminate six months from the date of consent without express revocation.

_____ I hereby consent to the release of any and all records containing alcohol and/or drug abuse and/or psychiatric diagnosis under the same consideration as outlined above. I understand that such information cannot be released without my specific consent, except in accordance with a court order.

_____ I further understand that I have a right to receive a copy of this authorization upon request.

Reason for Release: _____

Copy Requested: ☐ Yes ☐ No Copy Received: ☐ Yes ☐ No

Identifying Information:

Patient's Name at Time of Study: _____

Attending Physician: _____

Date of Birth: _____ Date of Treatment: _____

Information Requested:

☐ Discharge Summary ☐ History and Physical ☐ Operative Report ☐ X-ray

☐ Consultation ☐ Laboratory ☐ EKG, EEG ☐ Other: _____

Signed:

Patient, Parent or Legal Guardian: _____ Date: _____

**Your typed signature will serve in lieu of a handwritten signature*

AddressCity/State/ZIP: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Focus Sleep Centers is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI) and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. Focus Sleep Centers is also required to abide by the terms of the version of this Notice currently in effect.

Uses and Disclosures of PHI: Focus Sleep Centers may use PHI for the purposes of treatment, payment, and health care operations, in most cases, without your written permission. Examples of our use of your PHI:

For treatment. This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses, who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment and may transfer your PHI via radio or telephone to the hospital or dispatch center.

For payment. This includes any activities we must undertake to get reimbursed for the services we provide you, including such things as submitting bills to insurance companies; making medical necessity determinations; and collecting outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Reminders for scheduled appointments and information on other services. We may also contact you to provide you with a reminder of any scheduled appointments or to provide information about other services we offer.

Use and Disclosure of PHI Without Your Authorization: Focus Sleep Centers is permitted to use PHI *without* your written consent or opportunity to object in certain situations, and unless prohibited by a more stringent state law, including:

- For the treatment, payment, or health care operations activities of another health care provider who treats you
- For health care and legal compliance activities
- To a family member, close personal friend, or other individual involved in your care if we obtain your verbal agreement to do so; or if we give you an opportunity to object to such a disclosure and you do not raise an objection; and in certain other circumstances where we are unable to obtain your agreement but believe the disclosure is in your best interest
- To a public health authority in situations as required by law (such as to report abuse, neglect or domestic violence)
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process
- For law enforcement activities in limited situations, such as when responding to a warrant
- For military, national defense and security and other special government functions
- To avert a serious threat to the health and safety of a person or the public at large
- For workers' compensation purposes, and in compliance with workers' compensation laws
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation
- For research projects, but this will be subject to strict oversight and approvals
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

Patient Registration

NOTICE OF PRIVACY PRACTICES (CONTINUED)

Patient Rights: As a patient, you have a number of rights with respect to your PHI, including:

The right to access, copy, or inspect your PHI. This means you may inspect and copy most of the medical information about you we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

The right to amend your PHI. You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is already correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

The right to request an accounting. You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment, or health care operations, or when we share your health information with our business associates, like our billing company or our Medical Director who interprets your study results. We are also not required to give you an accounting of our uses of PHI for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

The right to request we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you. Focus Sleep Centers is not required to agree to any restrictions you request, but any restrictions agreed to by Focus Sleep Centers in writing are binding on Focus Sleep Centers.

Internet, Electronic Mail, and the Right to Obtain a Copy of Paper Notice on Request. If we maintain a website, we will prominently post a copy of this Notice on our website. If you allow us, we will forward you this Notice by electronic mail instead of on paper. You may always request a paper copy of this Notice should you desire.

Revisions to this Notice: Focus Sleep Centers reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our website if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy officer.

Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments, or complaints you may direct all inquiries to our privacy officer.

Effective Date of This Notice: March 8th, 2017.

Policy reviewed by Focus Sleep Centers: November 2022

☐ I have reviewed this HIPAA Notice.