GARDEN STATE SLEEP CENTER REGISTRATION FORM

(Please Print)

Today's Date: Primary Care Physician:

PATIENT INFORMATION:

Last Name: First: Middle: □Mr. □ Miss □Dr. □ Mrs. □Ms.

Marital Status (Please check one) □ Single □ Married □ Divorced □ Seperated □ Widowed

Employment Status: □ Full Time □ Part Time □ Unemployed □ Retired □ Student

E-mail Address: Driver's License No.: Birth Date: Age: Sex:

Street Address: Social Security Number: Home phone No.:

P.O. Box: City: State: Zip Code:

Occupation: Employer: Employer Phone No.:

Referred to this sleep lab by: □ Self □ Relative □ Friend □ Dr. (Name)

Other family members seen here:

INSURANCE INFORMATION

Person responsible for account: Birth Date: Address (if different): Home Phone No.:

Is this person a patient here?: Is this patient covered by insurance?: □ Yes □ No □ Don't know

Occupation: Employer: Employer Address: Employer Phone No.:

Please indicate primary insurance: Subscriber's name: Policy No.: Group No.:

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Secondary Insurance (if applicable): Subscriber's Name: Policy No.: Group No.:

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

IN CASE OF EMERGENCY

Name of local friend or relative: Relationship to Patient: Home Phone No.: Work phone No:

AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize GSSC or insurance company to release any information required to process my claims. I also authorize Garden State Sleep Center to perform the procedures and treatments ordered and approved by my referring physician. I have read and understand my Patient Rights and Responsibilities and this facility's grievance procedure.

Patient/Guardian Signature: Date:

Garden State Sleep Center
49 Veronica Avenue Suite 105
Somerset, NJ 08873
732-246-3066

EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

Sex: □Male □ Female Age: _____ PSG #: _____

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 recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation. Please write your choice.

0 = would **NEVER** doze
1 = **SLIGHT** chance of dozing
2 = **MODERATE** chance of dozing
3 = **HIGH** chance of dozing

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	

Height: _____

Weight: _____

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WAKE UP TIME

5:00 A.M. is the standard wake-up time at Garden State Sleep Center after an overnight sleep study. If you have to get up earlier than this, please document the time in the space below.

_____ A.M.

CONSENT FOR PHOTO/VIDEO

I hereby authorize Garden State Sleep Center to photograph and/or video record me and my sleep study for medical purposes – to assist in the interpretation of the polysomnogram and in the education and training of staff.

I understand that my identity will not be disclosed if these materials are used for learning purposes.

I have been informed that activities which occur in the testing room may be recorded and that a toilet/bathroom is provided for full privacy.

Signature of patient, parent or legally responsible person: _____

Name of patient, parent or legally responsible person: _____

Date: _____ Witness: _____

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ASSIGNMENT OF BENEFITS

Insurance: _____
_____
_____
_____

RE: Patient Name: _____

Member ID: _____

DOB: _____

SSN: _____

To whom it may concern:

I, _____, authorize payment of medical benefits to Garden State Sleep Center for services specified below.

Please mail check payable to: Garden State Sleep Center

49 Veronica Avenue Suite 105

Somerset, NJ 08873

Thank you.

Today's Date	Date of Service	Type of Service	Signature
		Sleep Study	
		Sleep Study with PAP Titration	
		MSLT	

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Sleep Study Consent Form

- My physician has informed me that I need a sleep study performed, specifically, _____ (Name of test), in the interest of my health and proper medical care.
- My physician has explained that procedure to me and the benefits and risks of having the test performed.
- My physician has explained to me that I may need CPAP (Continuous Positive Airway Pressure) therapy during the sleep study.
- I have had the opportunity to ask questions, and I consent to the sleep study.

Signature of Patient: _____ Date: _____

Time: _____ AM/PM

Signature of Parent/Guardian: _____

Indicate Relationship: _____

Witness: _____

TO BE COMPLETED FOR ADDITIONAL PROCEDURE/TREATMENT:

_____ _____

Authorized Signature Date

_____ _____

Witness Date

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Patient Name: _____ Date of Birth: _____

Date of Service: _____

INFORMED CONSENT FOR TREATMENT/PROCEDURE

PROPOSED PROCEDURE/TREATMENT: _____

I acknowledge that _____ has informed me of the following:

1. My diagnosis, if known
2. My basic rights and responsibilities as a patient
3. The nature and details of the procedure/treatment
4. The purpose of the procedure/treatment
5. The potential risks of the procedure/treatment
6. The potential benefits of the procedure/treatment
7. The alternatives available, if any
8. The risks and benefits of the alternatives
9. The potential risk if the procedure/benefit is not performed

I acknowledge that I have had an opportunity to ask all the questions I have regarding this condition or disease and concerning the available treatments and/or procedures. All questions have been answered to my satisfaction.

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 a cure or outcome of any medical treatment or procedure.

I hereby authorize the above-names provider and designated associates and assistants to perform the treatment or procedure named above.

_____ _____

Authorized Signature Date

_____ _____

Witness Date

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Notice of Privacy Practice

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our Privacy Officer at 732- 246- 3066. You may have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I acknowledge review/receipt of Garden State Sleep Center's "Notice of Privacy Practices."
( ) Yes ( ) No

Signature: _____ Date: _____

Print Patient's Name: _____

Relationship to Patient: _____

Print Name of Legal Representative (if applicable) _____

FOR OFFICE USE ONLY

Good Faith Effort was attempted to have the patient sign for receipt of the "Notice" and the patient refused to sign.

Staff Initial: _____ **Comments: _____**

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Authorization for Release of Information

I, _____, (Date of Birth) _____ currently living at

_____ authorize:

(Street Address) (City) (State) (Zip Code) (Phone)

(Name and address of facility releasing information)

to release the following information to: **GARDEN STATE SLEEP CENTER**

__ Medical records __ Overnight Sleep Study Results __ MSLT Results

Regarding the services of (date):

The requested information will be used for:

( ) Continued Care ( ) Personal ( ) Insurance ( ) Other: _____

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 or person specified above. 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 specified above. 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 specified above. 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.

This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me. If revoked earlier, it is understood by all parties that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization of 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 42-CFR-2 prohibits 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.

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BEDTIME QUESTIONNAIRE

Name: _____ Date: _____

Sex: □ Male □ Female PSG #: _____

1. What time did you awaken today? _____
2. How many hours of sleep did you get last night? _____
3. Was last night a restful night? □ Yes □ No □ I don't know
4. Did you take any naps today? □ Yes □ No How long? _____
5. Did you take any medications today? □ Yes □ No Please list below:

   _____ _____

   _____ _____

   _____ _____
6. When did you last eat? _____ Was this a □ Meal or □ Snack?
7. Have you had any of the following today? If so, how much?

   Caffeinated beverages □ Yes □ No _____

   Alcoholic beverages □ Yes □ No _____

   Cigarettes/Cigars □ Yes □ No _____
8. Did anything unusual happen to you today? □ Yes □ No If so, please explain:

   _____

   _____

   _____
9. Do you have any physical complaints right now? □ Yes □ No If so, please explain:

   _____

   _____

   _____
10. Do you feel ready for bed? □ Yes □ No If not, please explain:

    _____

    _____

    _____