LAS VEGAS SLEEP CENTER

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Las Vegas, NV 89117
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www.lvsleepcenter.com

NEW PATIENT INFORMATION FORM

Patient Name:_____ DOB:_____
Address:_____ Apartment #:_____
City:_____ State:_____ Zip:_____
Cell Phone:_____ Alternate Phone:_____
Email Address:_____
Social Security Number:_____
Marital Status:_____

INSURANCE INFORMATION

Primary Insurance Holder:
Name:_____ DOB:_____
Relationship to Policy Holder:_____
Primary Insurance Company:_____
Subscriber/Policy Number:_____ Group#:_____
Effective Date:_____ Type of Policy:_____
Secondary Insurance Policy Holder:
Name:_____ DOB:_____
Relationship to Policy Holder:_____
Secondary Insurance Company:_____
Subscriber/Policy Number:_____ Group#:_____
Effective Date:_____ Type of Policy:_____

RELEASE OF INFORMATION (Protected Health Information)

I hereby give authorization for the following person to obtain and or inquire regarding my medical information that I have provided to Las Vegas Sleep Center. This may include any financial/billing inquiries on services rendered.

Name of person who may inquire:_____
Relationship to Patient:_____

Patient Signature:_____ Date:_____

Patients Name:_____
D.O.B:_____

C.C.(Chief Complaint):_____

Weight:_____ lbs Height:_____ft/inches

Neck Circumference:_____ Inches

MEDICAL HISTORY

Do you use tobacco products?	___ Yes ___ No	How much per day?
Have you ever used tobacco products?	___ Yes ___ No	How much per day?
Do you eat/drink caffeine products? **(Chocolate, soda, coffee, tea, etc.)**	___ Yes ___ No	How much per day?
Do you consume alcohol?	___ Yes ___ No	How much per day?
Do you exercise?	___ Yes ___ NO	How often?

Medical Conditions (check all that apply)

___ CHF ___ Seizures ___ Sinus Problems ___ Diabetes ___ COPD
___ Stroke ___ Depression ___ Bruxism ___ Narcolepsy
___ Tonsillectomy ___ High Blood Pressure ___ Head Injury
___ Cardiac Arrhythmias ___ Thyroid Disorders ___ Eating Disorders
___ Iron Deficiency ___ Acid Reflux
___

Allergies:_____

List any other significant Medical History or Surgeries:_____

Family History (check all that apply)

___ Diabetes Mellitus ___ Obstructive Sleep Apnea___ Insomnia ___ Depression
___ Parkinsonism ___ Dementia ___ Other_____

Patients Name:_____
D.O.B:_____

SLEEP HISTORY

Have you ever had a sleep study before? ___ YES ___ NO YEAR_____
Where?_____
If you use a CPAP or OXYGEN, what pressure or level do you use?_____
Are you receiving **ANY** for a sleep disorder(s)? ___ YES ___ NO
If yes, describe:_____
What is your usual bedtime?_____
What is your usual wake time?_____
How long does it take for you to fall asleep?_____
How many hours do you sleep per night?_____
How many times do you usually wake at night?_____
What is your occupation?_____
How many naps do you take per day?_____
Do you keep a regular sleep schedule? ___ YES ___ NO
Do you have a regular work schedule? ___ YES ___ NO
Are you a shift worker? ___ YES ___ NO
Do you work a rotating shift? ___ YES ___ NO
Do you work in a hazardous environment? ___ YES ___ NO
Do you work in a quiet environment? ___ YES ___ NO
Do you have a bed partner or witness who has ever complained about your sleep habits?
___ YES ___ NO
Have any of your family members been diagnosed with a sleep disorder?
___ YES ___ NO

Do you have any of the following symptoms: (check all that apply)
___ Snoring ___ Sleepiness ___ Non-Restorative sleep ___ Fatigue ___ Gasping
___ Breath Holding ___ Choking ___ Breath Interruptions ___ Waking too early
___ Difficulty Staying Asleep ___ Difficulty Falling Asleep ___ Sleep Walking
___ Sleep Talking ___ Sleep Eating ___ Waking up Confused ___ Nightmares
___ Dream Reenactment ___ Frequent Leg Movement in Sleep ___ Bed Wetting
___ Sleep Hallucinations ___ Sleep Paralysis
___ Urge to move legs, uncomfortable sensation in the legs, worse with rest, briefly improved with movement, worse in the evening.

Patient Name:_____
D.O.B:_____

Do you awaken from sleep with any of the following: (check all that apply)

___ Dry Mouth ___ Nasal Congestion ___ Headache ___ Heartburn
___ Need to Urinate ___ Choking and Gasping ___ Nightmares ___ Teeth Grinding
___ Body Aches ___ Poor Sleep ___ Leg Discomfort ___ Reflux
___ Chest Pain ___ Cough ___ Seizures ___ Sweating
___ Environmental Noise ___ Panic Attacks
___ Other (please list):_____

MEDICATIONS

Please list all medications and supplements that you are currently taking:

Medication Name	**Dosage**	**How many times per day** (instructions)

Any Medication Allergies?_____

Primary Care Physician / Referring Physician_____

Patient Name:_____
D.O.B:_____

EPWORTH SLEEPINESS SCALE

The following questions pertain to your current lifestyle situation. If you have not performed some of these tasks recently, it is okay. Please try and remember how you felt the last time they were performed and how they affected you.

How likely are you to doze off or fall asleep in the following situations:

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

Situation	**Chance of Dozing**
Sitting and reading	___0 ___1 ___2 ___3
Watching TV	___0 ___1 ___2 ___3
Public Place (theater, meeting, church)	___0 ___1 ___2 ___3
As a passenger in a car for an hour without a break	___0 ___1 ___2 ___3
Lying down to rest in the afternoon when circumstances permit	___0 ___1 ___2 ___3
Sitting and talking to someone	___0 ___1 ___2 ___3
Sitting quietly after a lunch without alcohol	___0 ___1 ___2 ___3
In a car, stopped for a few minutes in traffic	___0 ___1 ___2 ___3

Total:_____

PHARMACY INFORMATION

Patient Name:_____ DOB:_____

Pharmacy Name:_____

Pharmacy Address:_____ City:_____ Zip:_____

Pharmacy Phone Number:_____ Fax:_____

Alternate Pharmacy or Mail-in Pharmacy Information:

Pharmacy Name:_____

Pharmacy Address:_____ City:_____ Zip:_____

Pharmacy Phone Number:_____ Fax:_____

This information is being obtained so we may electronically send or fax any prescription that does not require physical copies to be sent via our electronic system. The information provided will be added to our electronic medical records system and sent to the designated pharmacy.

Should any prescription require an authorization, the pharmacy must initiate the request so we may process the approval.

Patient Signature:_____

Date:_____

LAS VEGAS SLEEP CENTER

NO-SHOW AGREMENT

Patient agrees to pay a charge of $50.00 for failing to show up for their scheduled appointment. This goes for all New Patient and Follow Up appointments.

All patients are notified by phone/and or text, prior to their appointment. If you receive a phone call from the office and confirm your appointment, you are expected to arrive on time. If you receive a text message to confirm or reject your appointment, you have the option to choose one or the other. If you reject your appointment or do not reply to the text message, your appointment will be canceled.

The $50.00 no-show charge will be billed to you separate from any copay or deductible amounts owed. **This will not be billed to your insurance for payment.**

Patient agrees to respond to phone calls, emails, and text messages from our office in a timely manner.

Patient Name:_____

Patient Signature:_____

Date:_____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Las Vegas Sleep Center as your sleep medicine provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for the expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, co-payments, and patient billing. By signing below and/or by receiving medical services from Las Vegas Sleep Center, you agree to:

1). You acknowledge and agree to the established policies and procedures of Las Vegas Sleep Center, including but not limited to this **PATIENT FINANCIAL RESPONSIBILITY STATEMENT**, in effect from time-to-time (Policies). You may request a copy of the current Policies from the business office staff. These policies may be changed from time-to-time by Las Vegas Sleep Center, without notice. If there is any conflict between another policy or procedure of this office and this **PATIENT FINANCIAL RESPONSIBILITY STATEMENT**, this statement shall control.
INITIAL_____

2). You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our policies, which are not otherwise covered by supplemental insurance.
INITIAL_____

3). You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Las Vegas Sleep Center, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Las Vegas Sleep Center are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Las Vegas Sleep Center; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
INITIAL_____

4). You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card

on file, or are not able to verify your eligibility benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance, and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to pay your co-pay or other patient responsibility amount, your visit may be rescheduled by Las Vegas Sleep Center.

INITIAL_____

5). By signing below, you authorize Las Vegas Sleep Center to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign Las Vegas Sleep Center, for application onto your bill of services, all your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize Las Vegas Sleep Center and associated physicians, staff, and hospitals to release patient information acquired in the course of examination and/or treatment including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

INITIAL_____

6). If your insurance carrier does not remit timely payment on your claim (90-120 days), you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Las Vegas Sleep Center until your patient account is paid in full. If you make payment that results in surplus on your account, you authorize Las Vegas Sleep Center to apply the over-payment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a **financial responsibility party**, and any remaining balance will be returned to the payor.

INITIAL_____

7). You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect the billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for services incurred. If there is a problem with your account, it is your responsibility to contact the billing staff to address the problem or to discuss a workable solution.

INITIAL_____

8). Whether or not you have insurance or are self-pay, payment of any account balance is due at this office within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and referred to a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 2.5% per month or the maximum allowed by applicable law, whichever is lower. For small balances, under $25.00, we may stop sending billing statements any time after the initial statement, but you understand that the amount shall remain due and owing until paid in full.

INITIAL_____

9). We accept payment by check, debit, or credit card. **WE DO NOT ACCEPT CASH!**

- **Payment by Check:** If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $40.00 (forty) dollars or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Las Vegas Sleep Center, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus processing fee up to the state maximum legal limits (plus any applicable sales tax). **PLEASE NOTE:** The above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee. This does not, however, mean that Las Vegas Sleep Center cannot collect a returned check fee by other methods.
- **Payment by Debit/Credit Card:** You may pay with a debit or credit card. Your payment with a credit card may be made in person, by mail, or by calling the number provided on your billing statement. All regular credit card rules will apply. Once authorization on the submitted information is received, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information is used solely to process your payment. While processing your credit card payment, only the last 4 digits of your credit card are viewable by Las Vegas Sleep Center personnel.

INITIAL_____

10). **Managed Care (HMO, PPO, etc.):** All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care provider, you are responsible for presenting this before your initial visit. If you request an office visit without the referral authorization, your insurance plan may deem this as **"out of network"** or **"non covered"** treatment, and you will be responsible for a larger amount or all the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service deemed to be non-covered or not authorized by the plan.

INITIAL_____

11). **Medicare:** Las Vegas Sleep Center is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. By signing, you request that payment of authorized

Medicare benefits be made on your behalf to Las Vegas Sleep Center for any services furnished to you by Las Vegas Sleep Center.
INITIAL_____
12). **Medicaid:** If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and prior to the time of service. Your eligibility status will be verified monthly. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If at any time you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.
INITIAL_____
13). **Ancillary Services:** You may receive ancillary medical services while a patient of Las Vegas Sleep Center such as: interpretation of tests, sleep studies, mask fittings, and other DME services. By signing, you understand that the physician may not provide services in your presence, but is actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges with respect to such services after benefits paid on your behalf by any third-party are credited to your account.
INITIAL_____
14). **Additional Charges:** Patients may incur and are responsible for the payment of additional charges at the discretion of Las Vegas Sleep Center including but not limited to: (i) charges for returned checks; (ii) charges for missed appointments without 48 hours advance notice; (iii) charges for phone conversations and/or after-hours phone calls requiring treatment or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.
INITIAL_____
15). **Non-payment on Account:** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Las Vegas Sleep Center has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third-party collections agency, either as a flat fee or computed as a percentage of the total balance due to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency.
INITIAL_____
16). **Minor Patients:** The parent/guardian of a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied treatment unless charges for the treatment have been authorized.
INITIAL_____

17). **Authorization to Contact:** You authorize Las Vegas Sleep Center personnel to communicate with you by mail, text, and/or email according to the information provided in your patient registration information. Las Vegas Sleep Center, or any agent or servicing of your account, may use any information you have provided, including contact information, email, cell phone, landline, to contact you for purposes related to your account, including debt collection. You authorize Las Vegas Sleep Center to use this information in any manner consistent with the information you have provided, including mail, phone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.
INITIAL_____
18). **Financial Responsibility Party:** If this or a separate Las Vegas Sleep Center Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt, and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Las Vegas Sleep Center. This guaranty shall be continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said indebtedness shall be fully paid. There shall be no obligation on the part of Las Vegas Sleep Center at any time to first exhaust its remedies against patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.
INITIAL_____

Acknowledgment

By signing below, each of the undersigned acknowledges that: (i) have been provided a copy of the Las Vegas Sleep Center, **PATIENT FINANCIAL RESPONSIBILITY STATEMENT;** (ii) I have read, understand, and agree to the provisions and agree to the specified terms; (iii) I agree to pay all charges due (or become due) to Las Vegas Sleep Center for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by third-party will be credited on the patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this **Patient Financial Responsibility Statement** shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC SIGNATURE (DocuSign), I AGREE TO ALL THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient/Responsible Party/Guardian	**Date of Birth**	**Date**

Patient/Responsible Party/Guardian	**Date of Birth**	**Date**