The Insomnia and Sleep Institute of Arizona

8330 E Hartford Drive, Suite 100, Scottsdale, AZ 85255
1530 E Williams Field Road, Suite 204, Gilbert, AZ 85295
9305 W Thomas Road, Suite 465, Phoenix, AZ 85037
Phone: 480-745-3547 | Fax: 480-745-3548
sleeplessinarizona.com |info@sleeplessinarizona.com

PATIENT INFORMATION

Patient Full Name:_____ Date:_____/_____/_____

Address: _____

Home Phone:_____- _____- _____ Mobile Phone: _____- _____-_____

Marital Status: ❑Married ❑Single ❑Divorce ❑ Widow ❑ Other Email Address:_____

Sex: ____ Age: ____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian ❑ Black or African American ❑ White
❑ Hispanic ❑ Other Race ❑ Other Pacific Islander ❑ Refused to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refused to Report

Language: ❑ English ❑ Spanish

Employer Name: _____

Employer Address: _____

Business Phone: _____- _____- _____ Occupation: _____

Spouse Name: _____

Who should be notified in case of emergency? _____

Phone #: _____- _____-_____

Referring Physicians Name: _____ Primary Care Physician: _____

Address: _____ Address: _____

City: _____State: _____ Zip:_____ City: _____State: _____Zip: _____

Phone #: _____- _____- _____ Phone #: _____- _____-_____

Fax #: _____- _____- _____ Fax #: _____-_____-_____

INSURANCE INFORMATION *(MUST BE COMPLETED)*

PRIMARY INSURANCE NAME: _____

Address: _____ Phone #:_____

Policy #: _____ Group #:_____

Policy Holder Information *(if different)*

Policy Holder Name: _____Policy Holder Phone:_____

Policy Holder SS #: _____Policy Holder DOB: _____/_____/_____

SECONDARY INSURANCE NAME: _____

Address: _____ Phone #:_____

Policy #: _____ Group #:_____

Policy Holder Information *(if different)*

Policy Holder Name: _____Policy Holder Phone:_____

Policy Holder SS #: _____Policy Holder DOB: _____/_____/_____

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EMAIL, SMS (text messaging) & PATIENT PORTAL OPT-IN AGREEMENT

Email Opt-In

Dear Patient – We have implemented a follow-up and appointment reminder system that will send an email to you with information regarding your office visit. Studies show that more than 70% of patients say reminders help them remember an appointment. Check the box below to *Opt-In* and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anyone. You may choose to *Opt-Out* at any time.

☐ I would like to receive email correspondence for appointment follow-ups, reminders, or patient education information.
☐ I would **NOT** like to receive email correspondence for appointment follow-ups, reminders, or patient education information.

SMS (text messaging) Opt-In

Dear Patient – We have implemented a SMS (text messaging) system that is HIPAA compliant that will allow you to receive reminders and information regarding your office visit but also allow you to communicate directly with our staff by texting (480)745-3547 regarding any questions or concerns you may have. Studies show that more than 70% of patients say reminders help them remember an appointment but also the ability to more efficiently communicate with the office staff. Check the box below to ***Opt-In*** and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anyone. You may choose to ***Opt-Out*** at any time.

☐ I would like to **Opt-In** for SMS correspondence for appointment follow-ups, reminders, or patient education information as well other communication. *By checking this box, you agree to receive recurring messages from The Insomnia and Sleep Institute of Arizona, LLC. Replay STOP to Opt Out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undeliverable messages.*
☐ I would like to **Opt-Out** to receive SMS correspondence for appointment follow-ups, reminders, or patient education information or any other communication.

Patient Portal Opt-In

We have implemented a patient portal on our website that will allow for easier communication between you and The Institute. This patient portal will eventually allow for setting up appointments, requesting medication refills, and accessing your medical records. Check the box below to Opt-*In* and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anyone. You may choose to *Opt-Out* at any time.

☐ I would like to be setup with patient portal access.
☐ I would **NOT** like to be setup with patient portal access.

Patient / Guardian Signature:_____ **Date:** _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment direct and indirectly. 2) Obtain payment from third-party payers. 3) Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read, and understand Notice of Privacy Practices and Patient Bill of Rights containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used to disclose and carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree, then you are bound to abide by such restrictions.

Patient / Guardian Signature:_____ **Date:** _____

CONSENT FOR VIDEO TAPING

As part of a diagnostic sleep study, necessary videography is performed during the study to monitor for unusual behaviors during sleep such as seizure-type activity, sleep talking, sleep terrors, sleep walking, dream enactment behaviors, leg kicking, and/or any other unusual behaviors that will need to be reviewed by the physician to make an accurate analysis of your study. All information and data will be kept confidential and after review of the study by the physician, the video is archived and never shared with any party. I hereby authorize the use of videography for the purpose of medical diagnosis only. If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

Patient / Guardian Signature:_____ **Date:** _____

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PATIENT HISTORY

Name:_____ **Date:** _____

Occupational status: ☐ Employed ☐ Retired ☐ Student ☐ Stay-at-home ☐ Unemployed

Occupation (or prior occupation if unemployed/retired) : _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Other _____

Number of children: _____

Height: _____ **Weight:** Now: _____ One Year Ago: _____ Maximum: _____

Describe the main reason for your office visit or test with us:

_____

PERSONAL MEDICAL HISTORY: Current or treated in the past (Check all that apply):

☐ Healthy/No medical problems

☐ ADHD
☐ Anemia
☐ Anxiety
☐ Arthritis, Joint Pain
☐ Asthma
☐ Atrial Fibrillation
☐ Other abnormal heart rhythm (specify_____)
☐ Benign Prostatic Hyperplasia
☐ Bipolar Disorder
☐ Blood Clot
☐ Cancer (type_____)
☐ Cataracts
☐ Congestive Heart Failure
☐ COPD/Breathing problems
☐ Coronary Artery Disease
☐ COVID-19
☐ Dementia/Memory Loss
☐ Depression
☐ Diabetes (specify type I or II)
☐ Diverticulosis
☐ Eating Disorder
☐ Ehlers-Danlos Syndrome
☐ Emphysema
☐ Fibromyalgia
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart disease
☐ Heartburn/Gastric Reflux
☐ Hepatitis
☐ High Cholesterol
☐ HIV
☐ Hypertension/High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stones
☐ Leg/Foot Ulcers
☐ Liver Disease
☐ Obesity
☐ Osteoporosis
☐ Migraine Headaches
☐ Peripheral neuropathy
☐ Pneumonia
☐ Post-Traumatic Stress Disorder (PTSD)
☐ POTS/Dysautonomia
☐ Seasonal/Environmental allergies
☐ Seizures
☐ Stomach ulcers
☐ Stroke
☐ Traumatic Brain/Head Injury
☐ Urinary Tract Infections

Other Medical problems:
1._____
2. _____
3. _____
4. _____

SURGICAL HISTORY (Check all that apply):

☐ No surgeries

☐ Appendectomy	Year: _____
☐ Cardiac Bypass Surgery	Year: _____
☐ Gallbladder	Year: _____
☐ Hernia Repair	Year: _____
☐ Tonsillectomy	Year: _____
☐ Adenoidectomy	Year: _____
☐ Sinus Surgery	Year: _____
☐ Nasal Surgery (type: _____)	Year: _____
☐ Uvulopharyngopalatoplasty (UPPP)	Year: _____
☐ Maxillomandibular advancement	Year: _____
☐ Inspire (Upper Airway Stimulation)	Year: _____
☐ Pacemaker	Year: _____
☐ Hysterectomy	Year: _____
☐ Back/Spine Surgery	Year: _____
☐ Bariatric/Weight Loss Surgery	Year: _____

Other Surgeries:

1._____	Year: _____
2._____	Year: _____
3. _____	Year: _____
4. _____	Year: _____

ALLERGIES:

☐ Not allergic to any medications

☐ Penicillin ☐ Aspirin ☐ Sulfa
☐ NSAIDS ☐ Morphine ☐ Codeine

☐ Other allergies (please specify):_____

MEDICATIONS: (Prescription and over the counter drugs)

☐ **Not currently taking any medications**

	NAME	DOSAGE	TIMING	REASON FOR MEDICATION
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

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FAMILY HISTORY: *(Enter Yes for positive)*	MOTHER	FATHER
Living (L) or Deceased (D)		
Age (if living; or at time of death)		
Health (good or bad)		
Arthritis		
Asthma		
Dementia		
Depression		
Diabetes (Specify Type I or II)		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Kidney Disease		
Obesity		
Obstructive Sleep Apnea (OSA)		
Snoring		
Restless Leg Syndrome		
Narcolepsy		
Insomnia		
Osteoporosis		
Parkinson's Disease		
Stroke		
Substance Abuse		
Cancer (specify type):		
Other inherited conditions:		

SYSTEM REVIEW:	YES	NO		YES	NO
Fatigue/Excessive Sleepiness			Joint Pain		
Changes in Vision			Skin Rashes		
Dry Mouth			Headache		
Chest Pain or Palpitations			Depressed Mood		
Difficulty Breathing			Heat or Cold Intolerance		
Heartburn/Reflux			Abnormal Bleeding		
Difficulty with Urination			Itching/Hives		

PERSONAL HABITS:

Caffeinated Beverages:
Coffee: _____ per day
Tea: _____ per day
Soda: _____ per day
Energy drinks: _____ per day

Latest time of caffeine intake: _____

Alcoholic beverages:
Beer: _____ drinks per week
Wine: _____ drinks per week
Liquor: _____ drinks per week

Have you ever been treated for alcoholism? ☐ Yes ☐ No

Are you a:
☐ Current smoker (_____ packs per day)
☐ Former smoker (year quit _____)
☐ Never smoker

How often do you exercise?
☐ Never ☐ Occasionally ☐ Regularly
Type? _____
Time of day? _____

Do you have a history of drug use?
☐ Yes ☐ No
If so,
Medical Marijuana
☐ Current ☐ Former
Recreational Marijuana
☐ Current ☐ Former
Other drugs (cocaine, crack, heroin, etc)
☐ Current ☐ Former

Please answer all of the following questions as completely and accurately as possible because it will help in your correct diagnosis and treatment of your sleep related problems.

Have you ever had a Sleep Study Performed? ☐ Yes ☐ No
(If copies of these reports are available, please email them to our office, ask your prior facility to fax the records to us, or bring them with you to your appointment)
☐ In-lab Sleep Test ☐ Home Sleep Test ☐ MSLT Year:_____ Facility: _____
☐ In-lab Sleep Test ☐ Home Sleep Test ☐ MSLT Year:_____ Facility: _____
☐ In-lab Sleep Test ☐ Home Sleep Test ☐ MSLT Year:_____ Facility: _____
What was found? _____
How were you treated? _____
Do you consider the treatment to be successful? _____

If you were diagnosed with Sleep Apnea (OSA): ☐ N/A
Have you ever used CPAP? ☐ Yes ☐ No
Do you use CPAP now? ☐ Yes ☐ No
(If so, please bring your device and mask to your visit so that we can obtain a data download)
If you use CPAP: What is your current pressure setting? _____
What type of mask do you use?
☐ Full facemask ☐ Nasal mask ☐ Nasal pillows Brand/Model/Size (if known): _____
What is the name of the DME company (homecare company) that issues your equipment? _____
Describe any problems that you have, or have had, with CPAP: _____
Have you ever had surgery for sleep apnea? _____
Have you ever used a dental appliance for sleep apnea? ☐ Yes ☐ No

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GENERAL SLEEP INFORMATION:

1. How long have you had a sleep problem?_____
2. How many nights in a week do you have sleep problems?_____
3. On a typical night, what time do you get into bed?_____
4. How long does it take you to fall asleep after getting into bed_____
5. How many times do you wake up during an average night?_____
6. After you wake during the night, do you have difficulty returning to sleep? ☐ Yes ☐ No
7. What time do you wake up in the morning?_____
8. What time do you leave bed to start the regular daytime routine?_____
9. How many hours do you spend in bed on an average night?_____
10. How many hours do you actually sleep on an average night?_____
11. Does your sleep schedule change on the weekends? ☐ Yes ☐ No
    If so, Weekend bedtime: _____ Weekend wake time: _____
12. On average, how many days each week do you nap? _____
13. What time?_____ Length of nap?_____
14. What is your normal work schedule? _____
15. Do you consider yourself an: ☐ Early Bird ☐ Night Owl ☐ Neither

16. Which of the following do you typically do in the evenings to help you wind down before bed?
    ☐ Watch television ☐ Read a book ☐ Read on phone ☐ Listen to music
    ☐ Relaxation/Mediation ☐ Take a bath ☐ Other _____
17. Which of the following do you do while you are lying in bed trying to sleep?
    ☐ Watch television ☐ Read a book ☐ Read on phone ☐ Listen to music
    ☐ Relaxation/Mediation ☐ Lay quietly in bed until sleep onset ☐ Other _____
18.

Do you currently take, or have you ever taken, any medications to help you sleep? ☐ None			
Medication	**Currently Taking**	**Taken in the past**	**Comments**
Ambien/zolpidem	☐	☐	
Lunesta/eszopiclone	☐	☐	
Sonata/zaleplon	☐	☐	
Klonopin/clonazepam	☐	☐	
Xanax/alprazolam	☐	☐	
Ativan/lorazepam	☐	☐	
Restoril/temazepam	☐	☐	
Trazodone	☐	☐	
Seroquel/quetiapine	☐	☐	
Remeron/mirtazepine	☐	☐	
Hydroxyzine	☐	☐	
Belsomra/suvorexant	☐	☐	
Dayvigo/Lemborexant	☐	☐	
Melatonin	☐	☐	
Valerian	☐	☐	
Benadryl/diphenhydramine	☐	☐	
ZzzQuil	☐	☐	
Unisom	☐	☐	
Other (please list):			

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GENERAL SLEEP INFORMATION (CONTINUED):

19. Do you have a bedpartner who has watched you sleep? ❑ Yes ❑ No
20. Have you been told that you snore?
    ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently ❑ Unsure
    If so, is your snoring ❑ Soft ❑ Moderate ❑ Loud/disruptive
21. Has a bedpartner observed you to have pauses in breathing or disrupted breathing while you sleep? ❑ Yes ❑ No
22. Do you wake yourself gasping for air? ❑ Yes ❑ No
23. Do you have problems with any of the following?
    ❑ Morning headaches ❑ Waking with a dry mouth ❑ Teeth Grinding
24. On average, how many times per night do you use the restroom? _____
25. Do you have nasal congestion or stuffiness during the night? ❑ Yes ❑ No
26. Have you gained or lost significant amounts of weight in the past year? ❑ Yes ❑ No
27. Are you usually refreshed when you get out of bed? ❑ Yes ❑ No
28. Do you have difficulty concentrating? ❑ Yes ❑ No
29. Do have any problems with your memory? ❑ Yes ❑ No

30. If you have trouble sleeping, what do you think prevents you from sleeping well?
    _____
31. Is your bedroom dark, quiet, and comfortable? ❑ Yes ❑ No
    If no, please explain:_____
32. Does pain keep you awake at night? ❑ Yes ❑ No
33. Do you have racing thoughts at night? ❑ Yes ❑ No
34. Do you feel unable to relax? ❑ Yes ❑ No
35. Do you have frequent nightmares? ❑ Yes ❑ No
36. Do you see a psychiatrist or other mental health professional? ❑ Yes ❑ No
37. Do you use alcohol to try to help you sleep? ❑ Yes ❑ No
38. Do you feel that you have anxiety surrounding sleep that contributes to poor sleep quality? ❑ Yes ❑ No
39. Check any of the following that apply to you: ❑ Yes ❑ No
    ❑ Nightmares ❑ Ideas of suicide ❑ Difficulty with decisions ❑ Feeling Tense
    ❑ Depression ❑ Poor concentration ❑ Feeling panicky

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GENERAL SLEEP INFORMATION (CONTINUED):

40. How would you describe your energy levels in the daytime? *(choose one)*
    ____ Fully alert
    ____ Tired, but not falling asleep
    ____ Tired, and may fall asleep if circumstances permit (ie, while watching a movie at home), but able to stay awake in social situations
    ____ Extremely tired, and falling asleep involuntarily
41. Do you have difficulty staying awake while driving? ☐ Yes ☐ No
42. Have you ever been in a car accident or had a close-call related to drowsiness while driving?
    ☐ Never ☐ Car Accident ☐ Close-call
43. Have you ever experienced any of the following? (check all that apply)
    ☐ Hallucinations as you are drifting off to sleep or waking up
    ☐ Sleep paralysis (unable to move upon awakening)
    ☐ Sudden muscle weakness brought by being surprised or laughing hard

44. Do you feel an unpleasant need to move your legs in the evening? ☐ Yes ☐ No
45. If so, does this sensation prevent you from falling asleep? ☐ Yes ☐ No
46. Are the symptoms relieved by movement (stretching or walking)? ☐ Yes ☐ No
47. Are the symptoms worse in the evening? ☐ Yes ☐ No
48. Have you been told that you kick your legs frequently during the night? ☐ Yes ☐ No
49. Do you rub holes in your bedsheets where your feet lie? ☐ Yes ☐ No

50. Do you talk in your sleep? ☐ Yes ☐ No
51. Do you have a history of sleepwalking? ☐ Yes ☐ No
    If so, ☐ Current ☐ Childhood
52. Has a bedpartner ever told you that you kick, punch, fight, or appear to act out your dreams? ☐ Yes ☐ No

Is there anything else about your sleep that you feel is important to mention?

_____
_____
_____
_____

Patient/Guardian Signature: _____ Date:_____

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EPWORTH SLEEPINESS SCALE

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Patient Name:_____ DOB:_____ Date:_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't 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:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	0
Watching TV	0
Sitting, inactive in a public place (i.e.- a theatre or a meeting)	0
As a passenger in a car for an hour without a break	0
Lying down to rest in the afternoon when circumstances permit	0
Sitting and talking with someone	0
Sitting quietly after a lunch without alcohol	0
In a car, while stopped for a few minutes in traffic	0
Total (add each number from the 8 situations above)	_____

A score > 8 is indicative of pathological daytime sleepiness.
A score < 8 is indicative of normal level of daytime alertness.

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IMPORTANT INFORMATION FOR SLEEP STUDY PREPARATION

A fee of $300 will be charged for cancellations or changes within 72 hours of an appointment not payable by your insurance

- ❑ Please note the instructions for entry into The Institute facilities:

  FOR SCOTTSDALE: To the right of the main entrance there is an intercom/camera mounted to the wall. Press the intercom and your technician will buzz you in through the main doors.

  FOR GILBERT: To the right of the elevator on the 2nd floor, there is a corridor on the left with bathrooms; there is a door at the end of this hall that is the entrance for your sleep study. Press the intercom and your technician will come greet you at the door.

FOR PROBLEMS WITH ENTRY INTO THE FACILITY – CALL 480-745-3547 AND SELECT THE PROMPT FOR SLEEP STUDIES.

- ❑ Arrive to the sleep lab between 7:30 p.m. – 8:30 p.m. on the night of your study. If you need to arrive later please notify us in advance so that your sleep technician is aware.
- ❑ Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply makeup, face or body cream/lotion, as they may interfere with electric sensors.
- ❑ Take all your regular medications, unless instructed by your physician to do otherwise. Keep a record of your medications and the time taken. **Please bring any medication that you may need to take with you during your stay.**
- ❑ Please do **NOT** consume beverages or food containing caffeine after 12:00 p.m. on the day of the study.
- ❑ Try to get a full night of sleep the night prior to your study. Please do **NOT** take any naps the day of your study.
- ❑ Please bring nightclothes for the study. Loose fitting pajamas are preferred. Please avoid nightclothes that are made of satin, nylon, or silk because the chemicals/pastes could damage them.
- ❑ Feel free to bring personal belongings to your study that may help your sleep more comfortably, e.g., favorite pillow, blanket, book, etc.
- ❑ Bathrooms with shower stalls are available for your convenience. You may choose to bring a toothbrush, toothpaste, shampoo and soap for the morning to freshen up. In addition, you may have to wash your hair several times to remove the paste from your hair used during the study.
- ❑ You are usually free to leave by 6:00-6:15 am the following morning unless otherwise specified based upon your usual wake time.

SPECIAL INSTRUCTIONS FOR MULTIPLE SLEEP LATENCY (MSLT) TEST

1. The MSLT is performed the morning after an all-night sleep study ONLY for patients that are being investigated for narcolepsy.
2. Granola/Cereal bars and water are provided in the morning during this test. Please bring lunch with you, as well as any non-caffeinated, non-alcoholic beverages for use during the day.
3. Please bring reading materials to read during your stay with us**.** You may also bring a laptop for your use.
4. The urine toxicology test will be performed during the day of your study. Your insurance will be billed directly from the Laboratory (Labcorp or Sonora Quest) performing the test; if you know which lab your sample must go to because of insurance reasons please notify us in advance otherwise your sample will be sent to LabCorp.
5. The testing is usually concluded between 4:00-5:00 pm.

Additional questions in preparation for your sleep study – please contact the Director of Sleep Diagnostic Services at 480-745-3547.

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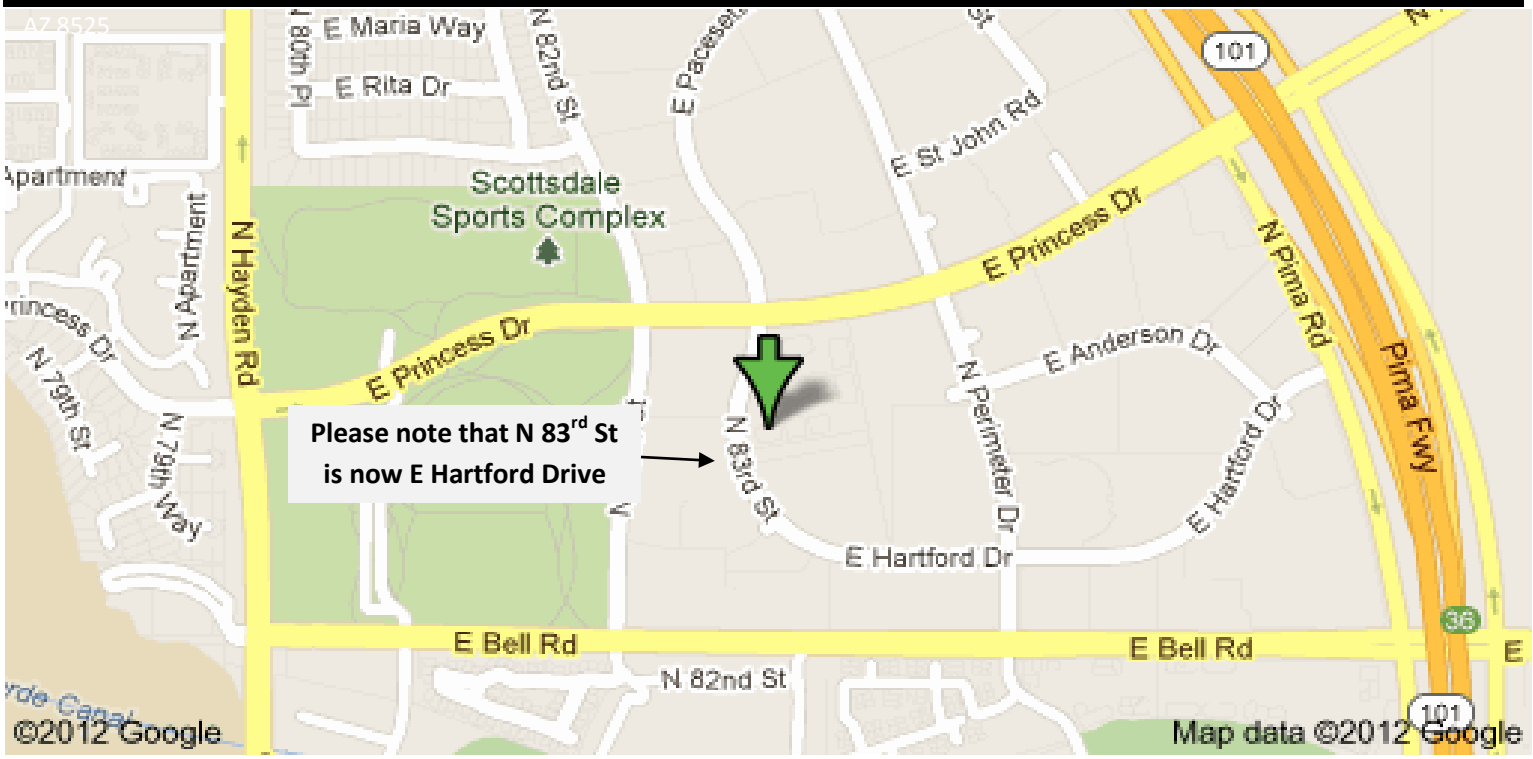
SCOTTSDALE MAP



From the East

Loop 202 West to
Loop 101 North
Take the Princess Dr. Exit, EXIT 36.
Turn left onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

8330 E HARTFORD DR is on the left.

From North Phoenix/Glendale/Sun City

101 South:
Take the Princess Dr. Exit, EXIT 36
Turn right onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

8330 E HARTFORD DR is on the left.

From Downtown Phoenix

51 North to
Loop 101 East
Take the Princess Dr. Exit, EXIT 36.
Turn right onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

8330 E HARTFORD DR is on the left

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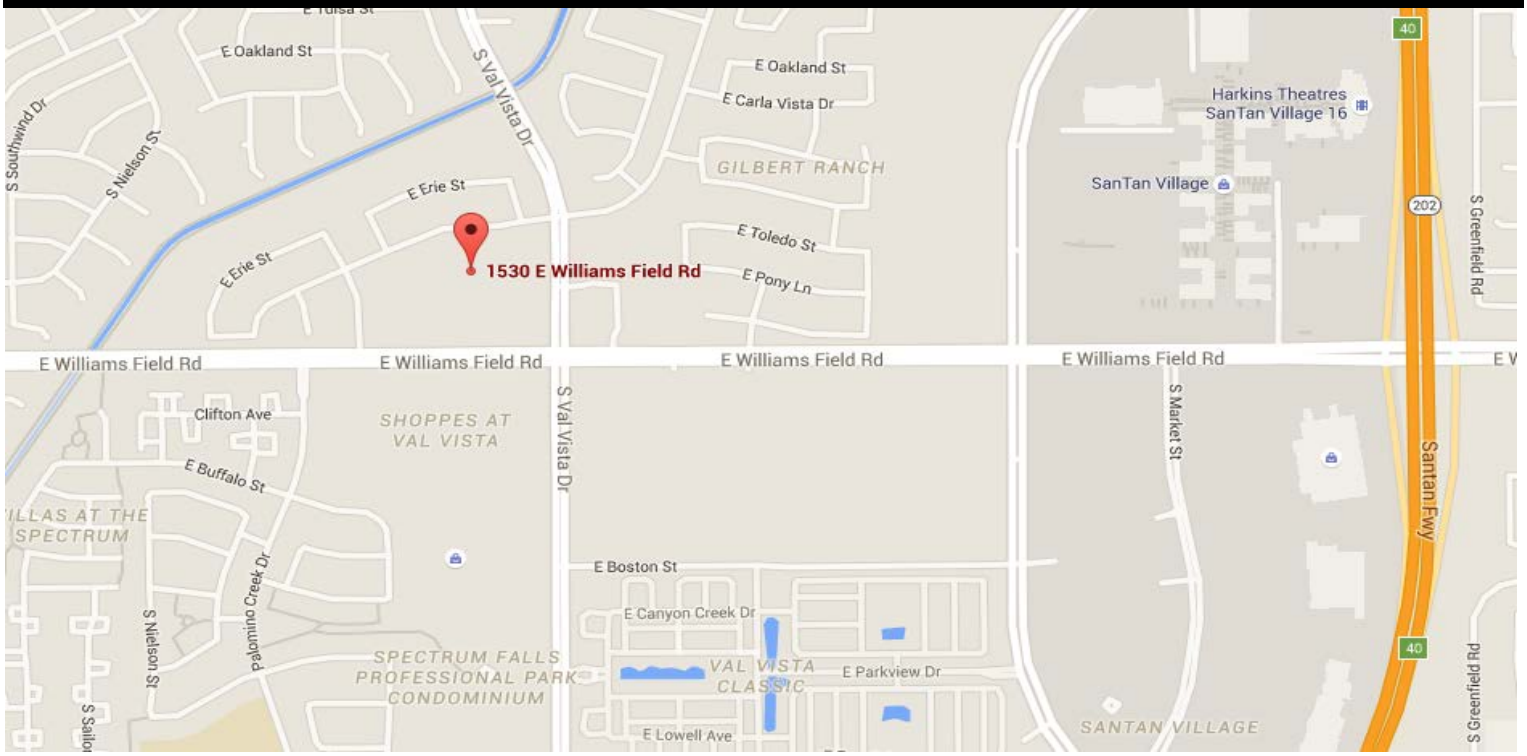
GILBERT MAP



From the East

Loop 202
Take Val Vista Drive Exit, Exit 42
Go North on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Drive and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

OR

Take E Williams Field Road Exit, Exit 43
Go West on E Williams Field Road to Val Vista Drive
Turn right into The Forum at Gilbert Ranch (just east of the intersection) / Building 1530 will be 2nd building on your right

PLEASE NOTE THERE IS AN ELEVATOR ON THE GROUND FLOOR OF BUILDING 1530 THAT CAN TAKE YOU TO THE 2ND FLOOR. ACCESS IS THROUGH THE DOOR MARKED WITH "ELEVATOR"

From the West

Loop 101 South to Loop 202 East
Take Val Vista Drive Exit, Exit 42
Go North on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Dr and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

OR

Loop 101 South to US 60 East
Take the Val Vista Drive Exit, Exit 184
Go South on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Drive and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

PLEASE NOTE THERE IS AN ELEVATOR ON THE GROUND FLOOR OF BUILDING 1530 THAT CAN TAKE YOU TO THE 2ND FLOOR. ACCESS IS THROUGH THE DOOR MARKED WITH "ELEVATOR"

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The Insomnia and Sleep Institute of Arizona

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9305 W Thomas Road, Suite 465, Phoenix, AZ 85037
Phone: 480-745-3547 | Fax: 480-745-3548
sleeplessinarizona.com |info@sleeplessinarizona.com

PATIENT INFORMATION

Welcome to our practice. We hope that your relationship with all the providers and staff at The Institute will be a longstanding relationship that is mutually beneficial. The Insomnia and Sleep Institute of Arizona is a practice that has special knowledge and training in the area of Sleep Disorders Medicine. We appreciate your confidence in our practice and would like to provide the following information in an effort to facilitate a positive doctor-patient relationship.

APPOINTMENTS: Office schedules do not allow for "drop in" appointment times. Please call and make an appointment with the medical receptionist so that you can address your concerns with the provider during a formal office visit. We try to avoid prolonged wait times for our patients by allotting enough time for each patient to interact with their doctor. While we cannot always anticipate patient's problems, we try to avoid situations that delay your visit with your physician. Please let our office staff know if you are experiencing an excessive wait time. Please show our practice the same courtesy by arriving at least 10 minutes early for your appointment. Late patients will usually be rescheduled as we do not believe it is fair practice to force a patient that has arrived early / on time for his or her appointment to have to make accommodations for late arriving patients.

NO SHOW AND APPOINTMENT CANCELLATIONS: We appreciate the courtesy of your call in the event you are not able to keep your appointment so that we may schedule another patient during that time. A minimum of 72 hours is required for appointment cancellations for a sleep study and 24 hours for an office visit; there will be a charge of $300 for a sleep study appointment and $100 for an office visit. We reserve the right to terminate our relationship with patients who habitually do not keep their appointments.

TELEPHONE CALLS: Our telephone and voicemail system are necessary to handle the volume of phone calls to our office. Please listen to the options carefully and choose the one that best suits your needs. For a faster response you can utilize the patient portal. The more information you can share in your message, the quicker and easier it will be to respond appropriately to your call. Our receptionists do not have the medical knowledge to make suggestions regarding your healthcare.

PATIENT CARE COMMUNICATION: You may utilize the HIPAA secure patient portal for any questions regarding your care. Should you seek Interprofessional telephone/Internet/electronic health record assessment and management services outside of a scheduled appointment, provided by a consultative physician, or other qualified health care professional, that requires 5 minutes or more of medical consultative time, that service will be billed to insurance per the contract. The possible codes that could be utilized for these services depending on the complexity and duration would be 99451-99452. Note this form of patient care communication is utilized as a form of consultation with your provider in lieu of an office visit.

PRESCRIPTION REFILLS: Please obtain prescriptions from your doctor at a scheduled office visit. However, if you need a refill, your need can be more easily met if you contact your pharmacist and have them call or fax us a refill request. Refill requests will be handled within 24 hours unless there is a problem and we notify you otherwise. Always check with your pharmacy first before calling the office. PLEASE do not wait until you are complet ely out of medication before calling your pharmacy. **Any refill request placed on Friday afternoon WILL NOT BE MADE until Monday morning. For controlled substances these refill request must be placed 72 hours before you would like to collect them.** Refill requests should be handled during regular office hours. Our proviers will not authorize refill requests on nights or weekends.

SLEEP STUDY RESULTS: The results should be available within a reasonable amount of time after completing your sleep study. Sleep study results will be discussed during your follow-up appointment with the provider. They will not be given out over the phone and or via e-mail.

COMPLETION OF FORMS: As a result of the amount of time that it takes to complete the various forms that are needed for FMLA, family medical leave, etc., there will be a charge of $25 per request for the completion of these forms.

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PRINTING/COPYING: The initial 50 pages will be free for printing or copying your medical records but after 50 pages each subsequent page will be $0.10 / page.

EMERGENCIES OR ILLNESS AFTER HOURS: If you are having a medical emergency please contact 911.

INSURANCE, DISABILITY and MEDICAL RECORDS: There are increasing numbers of forms that are requested to document disability and/or insurance benefits eligibility. Various documents request an enormous amount of information. Our policy is to provide adequate medical information pertinent to your request and must be accompanied by an authorization to release medical information. Additionally there will be a charge of $25 for all form completion. Should you need a copy of your medical records, an authorization to release medical records should be completed. Please allow 2 weeks for completion of forms.

HIPAA: Our office adheres to all mandates under the current HIPAA (Health Information Portability and Accountability Act). Please ask to speak with our HIPAA Compliance Officer if you have any questions regarding this act and your privacy issues.

I have read the above patient information and a have a full understanding of all of the items discussed.

Patient's Name: _____

Responsible Party (If not the Patient): _____

_____ _____
Signature of Patient or Responsible Party Date

For questions or concerns, please contact Brett Hundley, Practice Administrator at 480-745-3547.

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FINANCIAL / INSURANCE POLICIES

FINANCIAL POLICY: You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms. Please note that your insurance coverage is a contract between you and your insurance company. We will submit claims on your behalf as a courtesy.

INSURANCE PLAN PARTICIPATION: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company and verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

PROOF OF INSURANCE: All patients must keep on file current insurance cards. At your initial visit we will also require a copy of your driver's license. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card(s).

UPDATED CHANGE OF INFORMATION & COVERAGE: We will ask you to update this whenever you have a change of address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

COPAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of services. Payment of your co-payment, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered an act of fraud by your insurance plan.

PROCEDURE PREPAYMENT: We collect your payment for a procedure prior to the procedure taking place. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayment has been made.

NON-COVERED SERVICES: Please be aware that some or perhaps all of the services you receive may not be covered by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.

REFERRALS: Some insurance plans require a referral from a primary care physician to obtain services from a specialist. Your insurance carrier may have stipulations regarding the type of referral such as paper, verbal or through the insurance company's website. These plans will not pay for services without the proper type of referral. It is **YOUR** responsibility to obtain a referral prior to your visit. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.

AUTHORIZATIONS: Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at the time meets medical necessity for the services and not a guarantee of payment. Your insurance company will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.

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INSURANCE BENEFITS: We will contact your insurance company to obtain benefits for you. However please be aware that the information supplied by your insurance is only "quote of benefits" and may not be honored by your insurance company. The quote of benefits is subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of your health benefit plan at the time services are rendered. The payment decision will not be made until after the claim is submitted.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply with your insurance plan's request may result in your claim denial and if so, this will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

SELF-PAY: If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service unless you make other arrangements with our billing department. The current self-pay fee schedule is available from our front desk.

NON-PAYMENT: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and made arrangements. If the account remains unpaid, we will turn your account over to a collection agency after the 90th day past due. You agree to pay for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

REASSIGNMENT OF BALANCES: If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

PAYMENT METHODS: We accept cash, personal checks, money orders, cashier's checks, MasterCard, Visa, Discover and American Express as payment for services rendered.

RETURNED CHECKS: A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the first occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.

REFUNDS: Refunds for overpayment or prepayment on canceled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: The Insomnia & Sleep Institute of Arizona, ATTN: Billing Department, 8330 E Hartford Drive, Suite 100, Scottsdale, AZ 85255-7205.

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This is an agreement between The Insomnia & Sleep Institute of Arizona and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

Patient's Name: _____

Responsible Party (If not the Patient): _____

_____ _____
Signature of Patient or Responsible Party Date

For questions or concerns, please contact Brett Hundley, Practice Administrator, at 480-745-3547.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Please check one only:

☐ I only want my medical information released to myself.

☐ I give The Insomnia and Sleep Institute of Arizona and staff authority to release medical information regarding my care to the individuals listed below. This authority will be in effect for one (1) year.

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Name: _____

Relationship to Patient/Phone: _____

Patient Signature: _____ Date: _____

Witness: _____

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PRIVACY PRACTICE NOTICE

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

The Insomnia and Sleep Institute of Arizona takes your privacy seriously. We want to tell you about our privacy practices to protect your personal health information.

How do we use health information?
The Insomnia and Sleep Institute of Arizona uses your health information to treat you, to obtain payment for services, and to conduct normal business known as healthcare operations. Examples of how we use your information include:

Treatment – We keep a record of each visit. This record may include an initial evaluation, treatment plan, and notes.

Payment – We document the services you receive at each visit so that you, your insurance company or another third party can pay us. We may also tell your health plan about upcoming services that require their prior approval.

Health Care Operations – Health information is used to improve the services we provide, to train staff and students, for business management, for quality improvement, and for customer service. We comply with all applicable state and federal laws, including any laws that impact our ability to use your health information for treatment, payment and operations.

Other Services
We may also use information to:
• Recommend treatment alternatives
• Tell you about benefits and services
• Communicate with family or friends involved in your care
• Communicate with other healthcare providers or business associates for treatment, payment or health care operations. Business associates must follow our privacy rules.
• Send appointment reminders. You may tell the scheduler that you do not wish to have an appointment reminder.*

Information we share
There are limited times when we are permitted or required to disclose health information without your signed permission. These situations are listed below:
• For public health activities such as tracking diseases or medical devices
• To protect victims of abuse or neglect for federal and state health oversight activities such as fraud investigations
• For judicial or administrative proceedings
• If required by law or for law enforcement
• To coroners, medical examiners and funeral directors
• For organ donation
• To avert serious threat to public health or safety
• For specialized government functions such as national security and intelligence
• To Workers' Compensation if you are injured at work
• To a correctional institution if you are an inmate
• For research following strict internal review to ensure protection of information.

We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or health care operations of the organized health care arrangement.

Our Responsibilities
The Insomnia and Sleep Institute of Arizona is required by law to:

• Maintain the privacy of your health information
• Provide this notice of our duties and privacy practices
• Abide by the terms of the notice currently in effect.

We reserve the right to change privacy practices, and make the new practices effective for all the information we maintain. Revised notices will be available to you.

Your Rights
You have the right to:
• Request that we restrict how we use or disclose your health information. We may not be able to comply with all requests.
• Request that we use a specific telephone number or address to communicate with you
• Inspect and copy your health information (fees may apply)*
• Request additions or corrections to your health information*
• Receive an accounting of how your health information was disclosed (excludes disclosures for treatment, payment, healthcare operations, some required disclosures, as well as disclosures that you authorize)*
• Obtain a paper copy of this notice even if you receive it electronically.
• If you are a Medicare recipient, and believe The Insomnia and Sleep Institute of Arizona may have committed a fraudulent act, you have the right to make a formal complaint. The Medicare number is 1-800-633-4227

Requests followed by a star (*) must be in writing.

All other uses and disclosures, not previously described, may only be made with your signed authorization. You may revoke your authorization at any time.

To Contact Us
If you would like to exercise your rights, or if you feel your privacy rights have been violated, or if you need more information, contact Brett Hundley, at 480-747-3547
Or, by mail at: The Insomnia and Sleep Institute of Arizona, 8330 E. Hartford Drive, Suite 100, Scottsdale, AZ 852555

All complaints will be investigated and you will not suffer retaliation for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, D.C.

Our schedule of rates is available upon request Department of Health Inspection reports are available upon request

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PATIENT RIGHTS NOTICE

To provide an environment that respects and protects the rights of our patients and their families, we provide this listing of patient rights and responsibilities

You have the right:

- To be treated with dignity, respect and consideration. Care is provided without discrimination as to your race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis.
- To participate or have your representative participate in the development of, or decisions concerning treatment including consent or refusal for treatment except in an emergency. You or your representative may also refuse or withdraw consent for treatment before treatment is initiated.
- Except in an emergency, is informed of alternative to a proposed psychotropic medication or surgical procedure and associated risks and possible complication of a proposed psychotropic medication or surgical procedure.
- To be informed of the center's policy on health care directives and patient compliant process.
- To receive privacy in treatment and care of personal needs.
- To participate or refuse to participate in research or experimental treatment.
- To receive assistance from a family member, your representative, or other individual in understanding, protecting, or exercising your rights.
- To review upon written request, your own medical record according to A.R.S 12-2293, 12-2294, and 12-2294.01
- To receive a referral to another health care institution if we are not authorized or not able to provide physical health services or behavioral health services needed.
- To be free from mental, physical, sexual and verbal abuse or assault, neglect, coercion, manipulation and exploitation. Any allegations are promptly investigated and appropriate action is taken.
- To be free from restraint, except when it is temporarily necessary to prevent injury to yourself and others. Such emergency restraint is used in a safe manner and with care and respect.
- To privacy, confidentiality and security. Your personal privacy will be respected to the extent possible in a healthcare setting. We will make sure that you and your property are safe and secure.
- To consent to being photographed before you are photographed. Exception being you will be photographed at your initial appointment for identification and administrative purposes.
- To provide written consent to the release of information in your medical or financial records except as otherwise permitted by law.
- To speak with someone about your concerns if you are not satisfied with any aspect of your care and are unable to resolve the situation.
    - You may discuss it with the office administrator at 480.745.3547 or fill out a patient compliant form. These forms are available at the front desk.
    - If your concern is not resolved to your satisfaction you have the right to request a review without retaliation by:

      AZ Department of Health

      150 N. 18th Avenue
      Phoenix, AZ 85007
      Phone: 602.542.1025
      Fax: 602.542.0883

      Or the Department of Health Services Center for Medicare and Medicaid Services (CMS) call 1-800-MEDICARE

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