Sweet Dreams Sleep Center, INC.

WE WOULD LIKE TO WELCOME YOU TO SWEET DREAMS SLEEP CENTER. WE WILL DO EVERYTHING POSSIBLE TO MAKE YOUR STUDY A PLEASANT EXPERIENCE. IF THERE ARE ANY QUESTIONS DO NOT HESITATE TO ASK THE TECHNICIAN. WE DO WANT TO INFORM YOU THAT THERE IS A NO SMOKING POLICY ANYWHERE ON THESE PREMISES WHICH INCLUDES YOUR CAR OR THE PARKING LOT. BELOW IS SOME INFORMATION ON WHAT IS A SLEEP STUDY?

Type 1: Polysomnogram

A sleep study is a method that records brain waves, breathing patterns, muscle activity, heart activity, oxygen saturation and eye movement while you are sleeping. Sensors, electrodes, and monitoring equipment will be attached to the body with tape paste prior to bedtime. These sensors transmit data to a computer and recording continuously monitored by a certified technologist. A technologist will monitor and keep a record throughout the night. He or she will be available to assist you with anything you need including trips to the restroom. You will be video monitors to document sleep position including snoring and any other activity that happens throughout the night. If your test is positive for sleep apnea, then a second overnight stay is required to prepare you for the use of CPAP.

Type 2: Split-night Sleep Study:

If your physician has ordered a split night study, the technologist will assist you using CPAP (Continuous Positive Airway Pressure) therapy will be considered after 2 hours of diagnostics monitoring.

What is Continuous Positive Airway Pressure?

CPAP is a machine used to treat sleep apnea. Positive air pressure is delivered through a nasal or mask and using splints to open the airway. This positive pressure will prevent obstruction or collapsing of the airway that causes apnea which means pauses in breathing. During this part of the test, the technologist will adjust the levels of the air pressure to determine what level works best for you.

What happens after the study

The recording of your sleep study will be stored permanently at Sweet Dreams Sleep Center. It will be interpreted and analyzed by a board certified doctor. The information will be forwarded to your referring doctor and you will be contacted by a representative at Sweet Dreams Sleep Center as soon as the results are available.

Patient Signature:_____

SWEET DREAMS SLEEP CENTER,INC.

PATIENT REGISTRATION Today's Date_____

Patient Name:_____ Date Of Birth:_____

Mailing Address:_____City:_____

State:_____Zip Code:_____ Email Address:_____

Social Security#:_____ Height:____ Weight:_____

Gender:__Male__Female Marital Status:__S__M__D__W

Phone:(H)_____(C)_____

Occupation:_____Employer:_____

Employer's Address:_____

Referring Physician:_____

Emergency Contact:_____Relationship:_____

Phone Number:_____ How did you hear about us:_____

*PRIMARY INSURANCE COMPANY NAME:_____

CITY:_____STATE:____ZIP:_____PHONE #_____

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT _____

SSN OF POLICY HOLDER_____ DATE OF BIRTH:_____

*SECONDARY/SUPPLEMENTAL INSURANCE NAME:_____

CITY:_____STATE:____ZIP:_____PHONE #_____

POLICY HOLDER:_____ RELATIONSHIP TO PATIENT _____

SSN OF POLICY HOLDER_____ DATE OF BIRTH:_____

Sweet Dreams Sleep Center, INC.

MEDICAL HISTORY QUESTIONNAIRE CHECK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS

__Yes __No Acid Reflux/Heartburn

__Yes __No Anemia/Iron Deficiency

__Yes __No Arthritis/Muscle aches

__Yes __No Cancer

__Yes __No Cardiac arrhythmia

__Yes __No Congestive Heart Failure

__Yes __No Connective Tissue Disease

__Yes __No Depression/Anxiety

__Yes __No Diabetes

__Yes __No End Stage Renal Disease/Dialysis

__Yes __No Fibromyalgia

__Yes __No Heart Failure/Heart Attack

__ Yes __No HIV

__ Yes __No Hypertension

__ Yes __No Hot Flashes/Menopause

__Yes __No Lung Problems/COPD/Asthma

__Yes __No Nasal Congestion/Allergies

__Yes __No Pacemaker

__Yes __No Parkinson's Disease

__Yes __No Pulmonary Hypertension

__Yes __No Seizures

__Yes __No Stroke/Tia

__Yes __No Thyroid Disease(under/over)

Other: (please specify)_____

List any previously diagnosed sleep disorders: _____

Do you have a Advance Directive ____Yes ____ No Would you like us to keep one in file____Yes____No

List all prescription and non-prescription medications you are currently taking:

Medication	Reason Taken	Dose

Are you allergic to any medications - ___*Yes* __ *No* If so, please list below:

List all past or present medical conditions and/or surgeries

THE EPWORTH SLEEPINESS SCALE

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.

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	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Epworth Score	_____

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SLEEP HISTORY—SLEEP PATTERNS

1. How Long does it take you to fall asleep?_____

2. How many times do you awaken? _____

3. Do you feel un-refreshed and still sleepy upon awakening ?__Yes __No __Sometimes

4. How many hours of sleep does it take to make you feel rested?_____

5. Do you wake up too early and are unable to go back to sleep ?__Yes __No__ Sometimes

6. What is your usual sleeping position? __Back __Side __Stomach __Varies

SLEEP HISTORY QUESTIONNAIRE

___ Yes ___ No 1. Are you sleepy during the day?
___ Yes ___ No 2. Do you take naps? (If yes, how often? _____ weekly)
___ Yes ___ No 3. Do you dream during naps?
___ Yes ___ No 4 Have you ever experienced weakness or paralysis while laughing or angry?
___ Yes ___ No 5. Have you ever had hallucinations or dreamlike images while not actually asleep?
___ Yes ___ No 6. Do you have trouble concentrating or difficulty remembering things?
___ Yes ___ No 7. Do you snore?
___ Yes ___ No 8. Does your snoring disturb others?
___ Yes ___ No 9 Have you or anyone else noticed pauses in your breathing during sleep?
___ Yes ___ No 10. Have you ever awakened gasping or short of breath?
___ Yes ___ No 11 Do you awaken with a dry mouth or throat?
___ Yes ___ No 12. Do you have morning headaches?
___ Yes ___ No 13 Do you breathe through your mouth while you are asleep?
___ Yes ___ No 14 Do you experience unpleasant leg or arm sensations at bedtime?
___ Yes ___ No 15. Do you have pain which awakens you from sleep?
___ Yes ___ No 16. Do you have frequent nightmares or vivid dreams?
___ Yes ___ No 17. Do you grind your teeth or have you ever bitten your cheek during sleep?
___ Yes ___ No 18. Have you ever walked or talked in your sleep?

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Assignment of Benefits Form

Name of Insured (Print): _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

Financial Agreement:

I understand that payment for any services not covered or denied by my insurance (co-payments, deductible, pre-existing condition, failure to obtain a prior authorization or referral, etc.) will be my responsibilities. I understand that if my account is forwarded to a collection agency, I will be responsible for any and all reasonable collection and/or attorney fees.

Video and Monitoring Consent

As part of my diagnostic sleep study, I fully understand that video surveillance is required.

I hereby authorize the use of video surveillance for the purpose of medical diagnosis.

By signing this document, I also acknowledge that I have offered a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

ORGANIZATION
Sweet Dreams Sleep Center, INC.
373 East Brown Street, East Stroudsburg, PA 18301

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

Due to HIPPA Compliance Privacy Laws of the Federal Government,

It is mandatory that we ask you to review and answer the following questions listed below.

*Name:*_____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

*Home Phone*_____*Yes* _____*No*___ *Cell Phone:*_____*Yes*____*No*_____

*May we contact you at your place of employment? Yes*____ *No* ____

*If so may we leave a message? Yes*____ *No*___

*If yes: Work Phone:*_____*Extension:*_____

Do you have a particular person or family members that you authorize to receive and discuss

Information regarding your personal health information (general information and billing)?

*Yes*____ *No*___ *if yes, please provide*

*Name:*_____*Relationship*_____*Phone Number*_____

I hereby authorize Sweet Dreams Sleep Center, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, labs, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned information and provided my consent regarding any and all issues as stated above.

*Patient Signature:*_____*Date:*_____

*Witnessed by:*_____

ACHC REQUIRED (SLC2-5A)

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. ***Payment:*** Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health-care Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to quality assessment activities employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law; Public Health Issues As Required by Law; Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration Requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy the following records; psychotherapy notes; information compiled in reasonable anticipations of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may have been involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health-care Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services at 1-877-696-6775 or ACHC at 1-855-937-2242 if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. This notice was published and becomes effective on or before December 17, 2014. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with administration in person or by phone at 703-462-0831.

Signature below is only acknowledgement that you have received a copy of this Notice of Privacy Practices:

Print Name: _____

Signature: _____ ***Date:*** _____

PATIENT DECLINED COPY PAGE 10 AND 11

ACHC REQUIRED (SLC2-2A)(SLC2-4B)(SLC2-5A)