

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: _____



373 East Brown Street
East Stroudsburg, PA 18301
Phone: 570-241-9978
Fax: 570-392-6150

EQUIPMENT AGREEMENT

TODAY'S DATE: _____ DATE OF BIRTH _____

PATIENT NAME: _____

MAILING ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

Sweet Dreams Sleep Center, Inc. is loaning me Sleep portable monitoring equipment. I fully understand that due to other patients requiring this test I must make arrangements to have the equipment returned the next day which is

I agree that if I do not return the equipment or if the equipment is returned damaged, I will be liable for the replacement cost of the equipment. The value of the equipment given is the sum of \$2000.00

Patient Signature _____

Date _____

Provider/ Tech Signature _____

Date _____

Apnea link Serial Number _____

Sweet Dreams Sleep Center, Inc.
373 East Brown Street, East Stroudsburg, PA 18301
Telephone: 570-241-9978 Fax: 570-392-6150
Email: sweetdreamssleepcenter@gmail.com

Simple patient instructions: For Apnealink
Instructional video can be found on YouTube by looking up –
"How to use the ApneaLink Air Home Sleep Testing Device"

Please wear a "t-shirt" for this test

1. Place unit on table and unzip.
2. Stretch the black belt around your waist.
3. Slide the oximeter onto index finger (you may use the tape provided in the home sleep testing bag to hold the oximeter in place) Clip to black belt.
4. Attach the end of the nasal cannula to the side of the device by screwing in, then place the nasal cannula in your nose and slide chin adjuster to snug under chin- use the tape to hold cannula in place on cheeks.
5. Hold power button down for 3 seconds til light turns on (you will see all of the lights red until everything is connected, once everything is connected the lights will turn green.)
6. Sleep as you would normally.
7. When you wake up in the morning be sure to turn the device off by holding the power button down for 3 seconds.
8. Take all sensors off.
9. Return to office.

Place this in every home sleep study case.

If you have any questions during the night, please give us a call at our toll free emergency number at 844-724-5585.

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Instrucciones simple para el paciente: Para Apnealink
Este video se puede ver en la pagina de youtube –
“How to use the ApneaLink Air Home Sleep Testing Device”

Por favor pongase una camiseta para el examen

1. Ponga la unidad sobre la mesa.
2. Ponga la correa al redo de tu cintura.
3. Deslice el ometro en su dedo indice (Usted puede usar la cinta que se proporciona el la bolsa de prueba del sueno en casa para mantener el oximetro en su lugar. Fijelo al cinturon negro.
4. Fije el extreme de la canula del dispositivo atornillandolo, luego coloque la canula nasal el la nariz y deslice el ajustador de la barbilla para ajudtarlo debajo la barbilla: use la cinta para sujetar la canula en su lugar en las mejillas.
5. Mantenga presionado el boton de encendido durante 3 segundos hasta la luz encienda (Vera todas las luces rojas hasta todo este conectado, una vez que todo este conectado, las luces se volveran verdes
6. Duerma como normalmente
7. Cuando se despierte por la manana asgurase de apagar la machina mantiendo presionado el boton por 3 segundos
8. Quitese todos los sensors.
9. Devueva el equip a la oficina

Coloque esto en cada caso de studio del sueno en el hogar.

Si tienes alguna preguntas durante la noche, llamenos a nuestro numero de emergencia
844-724-5585

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Home and Equipment Safety Guidelines

GENERAL HOME SAFETY

1. Stairways should have safe and sturdy railings or banisters.
2. Keep stairways, halls and exits free from clutter, shoes, tools toys etc.
3. Stair surfaces should be non-slip type.
4. Wear shoes or slippers when up and about, rather than going barefoot.
5. Throw rugs should have a non-slip backing and should be avoided in traffic areas.
6. Waxed or highly polished floors can create slippery conditions.
7. Stairways and halls should be well lit.
8. Do not block stairways with furniture.
9. Storage place for often used items should be kept in easy reach.
10. Emergency phone numbers should be placed by the phone.
11. Wipe up spilled liquids and grease right away. Clean up any dropped food particles right away.
12. Store all poisonous and dangerous chemicals, such as cleaning agents, separate from food items and out of reach of small children and pets. All chemicals should be clearly labeled.
13. Report all incidents, accidents or safety hazards involving your medical equipment to us immediately!

BATHROOM SAFETY

1. Do not use electrical appliances in the bathtub or shower.
2. Use rubber mats or non-slip strips on the floor of the bathtub or shower.
3. Do not use soap-holder handles or towel racks as a grab bar for support when getting in or out of the tub.
4. Avoid using oils in the bath. This can make the tub slippery.
5. Make sure feet are dry before stepping on tile type floors.
6. Make sure water temperature is not too hot before getting into the tub or shower.

MEDICATION SAFETY

1. Check your Physician and/or Pharmacist to obtain any information regarding your medications including:
 - The name, dosage, and technique for administration.
 - Proper storage and handling.
 - Any significant precautions, side effects, or contraindications.
2. Be sure that all medicines are clearly labeled.
3. Be aware of expiration dates and discard any prescription medications that have exceeded their expiration date.

FIRE SAFETY

1. Smoke detectors should be placed on each level of the home and checked at least once a month for proper function.
2. Do not smoke in bed. If patient must smoke, never leave them unattended.
3. Do not use shallow ashtrays.
4. Turn pot handles toward the back of the stove.
5. Make sure long sleeves and loose parts of clothing are out of the way of fire when cooking.
6. When heaters are in use, make sure they are out of the way of fire when cooking.
7. In the event of a fire, you should:
Rescue people; Alarm the fire department 911; Confine the fire; Extinguish the fire
8. A fire extinguisher should be available. AABC type @ extinguisher is appropriate for all fires.
9. When operating a fire extinguisher always remember to:
Pull the safety Ring; Aim the nozzle at the base of the flames; Squeeze the handle; Sweep back and forth.

Home and Equipment Safety Guidelines:

ELECTRICAL SAFETY

1. Plugs and sockets should fit firmly and require some force to insert and remove.
2. If children are present in the home, all unused outlets should have childproof caps inserted.
3. Unplug any electrical cords that are warm to touch. Do not use them until they have been repaired or replaced.
4. Always grasp the plug to remove it from the outlet, **NEVER** pull the cord.
5. All electrical devices should be properly grounded unless they are "double insulated."
6. Cheaters which convert three-prong plugs into two-prong plugs may be used (if necessary) on a temporary basis until a 3-pronged outlet can be installed.
7. Avoiding using extension cords whenever possible.
8. Check cords for fraying, bare wires or other defects, especially where the cord attaches to the equipment.
9. Keep cords away from oil, grease or any material that causes deterioration.
10. Keep cords out of the way of traffic to prevent trip hazards.
11. Oxygen increased the flammability of other materials, take precaution to prevent sparks in the oxygen area.
NEVER use petroleum based products for any oxygen therapy patient.
12. **NEVER** touch an electrical appliance and plumbing at the same time.
13. **NEVER** run a cord across the sink or across a wet floor.
14. Make sure circuits are not overloaded.
15. Disconnect equipment that: sparks, stalls blows a fuse, or gives the slightest shock.
16. Repair to wiring and circuits should be done by qualified electrician only.

IN CASE OF ELECTRICAL FIRE

1. Get everyone out of the area.
2. Report the fire (call 911)
3. If the fire is small, such as a piece of equipment:
 - a. Pull the electrical plug, turn off the switch, or trip the circuit breaker.
 - b. Extinguish the fire with "Type C" fire extinguisher made specifically to put out electrical fires.
4. If the fire is large or threatens flammable materials, **DO NOT ATTEMPT TO FIGHT THE FIRE.**
5. **NEVER** use water on an electrical fire.

IN CASE OF ELECTRICAL SHOCK

1. **DO NOT TOUCH** the person shocked. If you touch the victim with your hands, you could also be shocked.
2. Turn off the power or plug to the machine appliance, or equipment.
3. If you are unable to cut off the power, call the electrical company.
4. Call your local emergency services to treat the victim.

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 your 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.

Sweet Dreams Sleep Center

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 _____

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