(Please Print)

Today's date:	Primary Physician: Name of Dr. or Person(s) who referred you to this office:

PATIENT INFORMATION

Patient's Legal Last name: First: Middle:				Marital status (circle one) Single / Mar / Div / Sep / Wid
(Former/Maiden Name):	Birth date: / /	Age:	Social Security #:	Sex: ❑ M ❑ F
Home address:	City:		State:	Zip Code:
Cell phone #: ( )	Home Phone #: ( )	E-Mail:		
Occupation:	Employer:			
Employer's Address:	Employer phone #: ( )			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for Payment:	Birth date: / /	Home phone #: ( )
Address (if different):		Cell phone #: ( )

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group #:	Policy #:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name :	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )

If we are a providing member on your insurance plan, we will bill your insurance for you. If not, you will be considered a cash account. We will provide you with the necessary insurance information that you will need to file your own claim.

Patient/Guardian signature: **Date:**

Patient Information Packet

Thank you for considering AmeriSleep Diagnostics for your sleep disorders needs. The information contained in this packet will help guide you through the sleep diagnostics process. At AmeriSleep Diagnostics we are committed to providing comprehensive sleep diagnostic services, while maintaining the highest level of integrity, quality, comfort and overall patient experience. Our dedicated and experienced staff is committed to maintain the highest standards and quality of care from beginning to end. We hope you enjoy your experience at AmeriSleep Diagnostics. If you have questions or concerns our staff would be happy to assist you further.

Services Offered at AmeriSleep:

Sleep Studies – We provide a full spectrum of diagnostic studies to evaluate snoring and sleep apnea, narcolepsy, restless legs, and other sleep disorders. Such studies include:

- **Polysomnography (PSG)** – An overnight sleep study in which sleep stages and breathing are monitored.
- **CPAP/Bi-level Titration** – A flow of positive-pressure air through a mask to splint the airway open for sleep apnea treatment
- **Multiple Sleep Latency Test (MSLT)** – An objective test to evaluate sleepiness and will also be used to measure the results of your treatment.
- **Maintenance of Wakefulness Test (MWT)** – An objective test used to document that a sleep/breathing treatment is effective. This test is required by transportation authorities to give employees the approval they need to return to their jobs after treatment for a sleeping disorder has been under way.
- **Home Sleep Test-** Diagnostic sleep study conducted in the comfort of ones home primarily used to diagnose obstructive sleep apnea.

Sleep Treatments –We will facilitate patient follow-up by educating patients with the latest comprehensive treatment options for sleep apnea including:

- CPAP Therapy
- Surgical Options
- Oral Devices

Follow-up – Our staff will ensure your treatment is effective through extensive follow-up and contact.

Patient Rights and Responsibilities

As a patient of Amerisleep Diagnostics, you have the right:

- To be treated with dignity and compassion and to have your privacy and property respected at all times; and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by our staff.
- To privacy and confidentiality of all records pertaining to your care, except as otherwise provided by law, and to have access to those records upon request.
- To receive care and services in a professional manner without discrimination on the basis of your age, sex, race, religion, ethnic origin, sexual preference, physical or mental handicap, or personal, cultural and ethnic preferences.
- To obtain complete and clear information concerning diagnosis, treatment and prognosis.
- To exercise your rights as a client, such as providing informed consent, or to have your authorized, designated representative exercise your rights as a client.
- To participate in the development and modification of your care and service plan; to refuse treatment, within the boundaries set by law, and to be informed of the consequences of any such refusal.
- To be informed of the services available at our facility, who will be providing care, and the fees and charges for such services and products provided.
- To be informed of any experimental treatment or research study and to refuse to participate in these projects.
- To express concerns, grievances or recommendations without fear of discrimination or reprisal and to be involved, as appropriate, in discussions and resolutions of conflicts and/ or ethical issues related to your care. Please report all concerns or grievances to the administrator of this facility.

And you have the responsibility:

- To keep appointments and when unable to do so, notify us immediately.
- To be considerate of other patients and personnel, and to control noise and other distractions while at our facility.
- To respect the privacy and property of others and the facility.
- To notify us when you feel ill, or encounter any unusual physical or mental stress or sensations while at our facility.
- To provide complete and accurate information concerning your health, medications, allergies, and other matters related to your healthcare and treatment.
- To notify us of any changes to your insurance coverage, place of residence, telephone number or medical history.
- To request additional assistance or information on any phase of your health care plan you do not fully understand.
- To actively participate in decisions about your healthcare and comply with treatment regimens.
- To promptly fulfill financial obligations to this facility by making payments when due, or by providing documentation or information to this facility in order to complete insurance claim filing.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your medical record

- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.govfocrfprivacyJhipaajcomplaintsf.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A *doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our clinic, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan* so *it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: December 19, 2018

Medical History

Name:		Date:
D.O.B.:		
Vital Statistics		
Height: feet inches	Weight:	Neck Size:
Current Medications		
Medication	*Dose*	*# Times Per Day*
Allergies:		

Past Medical History

- ❑ Hypertension (High Blood Pressure)
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Stomach/Colon Problems
- ❑ Lung Problems/COPD/Asthma
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ Stroke
- ❑ TIA "Light Stroke"
- ❑ Blackouts
- ❑ Seizures
- ❑ Back or Joint Problems
- ❑ Cancer
- ❑ Thyroid Problems
- ❑ Hepatitis/Jaundice
- ❑ Hearing Impairment
- ❑ Depression/Anxiety
- ❑ Alcoholism
- ❑ Chemical Dependency/Abuse

Other Past Medical Problems and Dates

Problems	*Dates*

Past Surgeries and Year Occurred

Surgery	*Year*

Epworth Sleepiness Scale

Name:_____ Date: _____

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

It is important that you answer each question as best as you can.

Situation	**Chance of Dozing (0-3)**
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g. theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

AmeriSleep DIAGNOSTICS

Dedicated to providing comprehensive diagnostics, education, and treatment services for sleep disorders.

Covid-19 Liability Waiver:

I acknowledge the contagious nature of the Coronavirus (COVID-19) and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Remsai Home Sleep Diagnostics, dba AmeriSleep Diagnostics has put in place preventative measures to reduce the spread of COVID-19. I further acknowledge that Amerisleep Diagnostics cannot guarantee that I will not become infected with COVID-19. I understand that the risk of becoming exposed to and/or infected by COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, AmeriSleep Diagnostics staff, and other AmeriSleep Diagnostics clients and their families. I voluntarily seek services provided by AmeriSleep Diagnostics and acknowledge that I am increasing my risk to exposure of COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

1. I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
2. I have not traveled internationally within the last 14 days.
3. I have not traveled to a highly impacted area within the United States of America in the last 14 days.
4. I do not believe I have been exposed to someone with a suspected and/or confirmed case of COVID-19.
5. I have not been diagnosed with Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
6. I am following all CDC recommended guidelines as much as possible and limiting my exposure to COVID-19.

I hereby release and agree to hold Remsai Home Sleep Diagnostics, dba AmeriSleep Diagnostics harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the AmeriSleep Diagnostic facility, or that may otherwise arise in any way in connection with any services received from AmeriSleep Diagnostics. I understand that this release discharges AmeriSleep Diagnostics from any liability or claim that I, my heirs, or any personal representatives may have against the AmeriSleep Diagnostics with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Amerisleep Diagnostics. This liability waiver and release extends to the AmeriSleep Diagnostics sleep center together with all owners and employees.

Signature: _____ Date:_____

Name: _____

Address
Daily 8pm to 6am
4025 Camino Del Rio S
Suite 103
San Diego, CA 92108

Scheduling Department
Ph: (619) 717-8102
Fax: (619) 754-2204

Billing Inquiries
Ph: (619) 746-6530

Certified Medicare Facility

Accredited Through ACHC (Accreditation Commission for Health Care)

Diagnostic In-Lab Services:
Home Sleep Test (HST)

Polysomnography (PSG)

Continuous Positive Airway Pressure (CPAP) Titration Test

Bi-Level Positive Airway Pressure (Bi-PAP) Titration Test

Adapto-Servo Ventilation (ASV) Test

Split-Night (PSG and CPAP) Study

Multiple Sleep Latency Test (MSLT)