



# SLEEP DISORDERS CENTER OF VIRGINIA

*Say Goodnight Virginia*

You have been scheduled for a consultation at Sleep Disorders Center of Virginia. Please read the following important information about your appointment. There is no testing involved during your first office visit. We will schedule you for any testing needed on a later date.

*If you are unable to keep this appointment, please contact our office one business day ahead to cancel. Failure to do so may result in a \$35.00 charge. Broken appointments prevent other patients from receiving timely care.*

*This form is not an insurance referral. You are responsible for bringing your referral number if your insurance requires. If you do not know whether you need a referral, contact your primary care physician well before your appointment.*

**Patient Name:** \_\_\_\_\_

**Date of Appointment:** \_\_\_\_\_

**Time:** \_\_\_\_\_ a.m. / p.m.

**Office:**

RICHMOND  
1800 Glenside Drive  
Suite 103  
Henrico, VA 23226  
(804) 285-0100

COLONIAL HEIGHTS  
130 Temple Lake Drive  
Suite 5  
Colonial Heights, VA 23834  
(804) 526-3450

HANOVER  
8405 Northrun Medical Drive  
Mechanicsville, VA 23116  
(804) 559-4165

MIDLOTHIAN  
6500 Woodlake Village Cir  
Midlothian, VA 23112  
(804) 888-6070

**Sleep Specialist:**  Martin F. Betts, M.D.  
 Suleman H. Iqbal, M.D.  
 Richard A. Parisi, M.D.

## **Please bring the following items to your first visit.**

- **Insurance referral if needed. If you are unsure whether or not you need a referral, please contact your primary care physician or insurance company well before your appointment date.**
- **Your health insurance card(s) and prescription drug card(s).**
- **Copies of any records from other physicians related to your sleep disorder – especially if you have seen another sleep doctor or had a sleep study in the past.**
- **If you have CPAP equipment, please bring your mask, tubing, CPAP unit, power cord, and humidifier.**

### **Virginia Prescription Monitoring Program**

The prescription monitoring program collects prescription data for Schedule II-IV drugs into a central database which can then be used by limited authorized users to assist in deterring the illegitimate use of prescription drugs. The information collected in this program is maintained by the Department of Health Professions, and strict security and confidentiality measures are enforced. Only those persons authorized by law can be provided information from the database, and the list of authorized persons is very limited. Prescribers and dispensers may query the database to assist in determining treatment history and to rule out the possibility that a patient is "doctor shopping" or "scamming" in order to obtain controlled substances.

Pharmacies, non-resident pharmacies, permitted physicians, and physicians holding a permit to sell controlled substances are required to report all dispensing of any Schedule II, III, and IV controlled substances to the PMP.

Sleep Disorders Center of Virginia may utilize the Prescription Monitoring Program to obtain patient histories.



# PATIENT INFORMATION

Every year we will ask you to fill out the following personal information. We do this in an effort to keep your records as current as possible.

If the patient is a minor, guardian information **MUST** be completed.

Date Completed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Race:  Hispanic  Asian  Caucasian  Black or African American  Native American  Multiracial  Pacific Islander  Other  
Ethnicity:  Hispanic/Latino  Non-Hispanic/Non-Latino

Preferred Language: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Other Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-Mail: \_\_\_\_\_@\_\_\_\_\_.\_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse/Significant Other's Name: \_\_\_\_\_

Spouse/SO's Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### To Protect Your Privacy

When your sleep doctor calls with **test results**, at which number do you prefer to be called during the day?

Home  Work  Mobile  Other: \_\_\_\_\_

Which number do you prefer we use for **appointment reminders**?

Home  Work  Mobile  Other: \_\_\_\_\_

May we send postcards in the mail to remind you of upcoming appointments or other related information?  Yes  No

May we send you e-mail you reminders for upcoming appointments and other appointment related information?  Yes  No

Is there a spouse, significant other, family member, or other person who has your permission to discuss your diagnosis and treatment with your sleep doctor?  Yes  No

**Please write the name of any person who has your permission to discuss your diagnosis and treatment with Sleep Disorders Center of Virginia, starting with your spouse/significant other if applicable. This permission shall remain in effect until revoked by you. You have the right to revoke permission at any time.**

Name	Relationship to You
	Spouse/Significant Other

Office Staff – Select **PATIENT INFO UPDATE** document type for this page



# GUARDIAN INFORMATION

## ALL MINORS MUST HAVE THIS FORM COMPLETED

Every six months we will ask you to fill out the following personal information.  
We do this in an effort to keep records as current as possible.  
If some information is the same as the patient's, please write "same" in blank.

Today's Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Name: \_\_\_\_\_

Legal Guardian Name: \_\_\_\_\_

Relationship to Patient:  Parent  
 Other Family Member:  
 Legal Guardian – Please present documentation to front desk

Guardian Street Address: \_\_\_\_\_

Guardian City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Guardian Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Guardian Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_

Guardian Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Does the minor patient reside in a group/facility home or hospital?  Yes  No – sign bottom and continue next page

If yes, please provide the name of the facility or hospital: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Facility City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

As the minor's legal guardian, I grant access to medical information as stated below, for the following group home / facility employees.

Group Home / Facility Employee Names: \_\_\_\_\_  
\_\_\_\_\_

These employees have permission to:

- Enter exam room with patient if needed
- Discuss medical information and test results with SDC physicians and staff
- Request and receive copies of the minor patient's medical records
- Discuss billing issues with SDC staff

Parent/Guardian Signature: \_\_\_\_\_

**PLEASE NOTE:** If the legal guardian is not a biological parent, you must present legal documentation to the front desk. This ensures the proper parties will have access to records as needed.

***If the patient lives in a group home, facility, or hospital setting, employees of the facility do not have access to medical records and/or information unless written permission is given by the legal guardian. Please bring documentation to your first appointment.***

Office Staff - Scan this page as PATIENT INFO UPDATE document type



# INSURANCE INFORMATION

Every year we will ask you to fill out the following insurance information. We do this in an effort to keep your records as current as possible. All fields are REQUIRED by your insurance company before payment will be considered.

Date completed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## PRIMARY INSURANCE

Name of Primary Insurance: \_\_\_\_\_

**Policyholder** Name: \_\_\_\_\_

Your Relationship to Policyholder: Self Spouse Parent Other: \_\_\_\_\_

**Policyholder** Date of Birth: \_\_\_\_\_

**Policyholder** Social Security: \_\_\_\_\_

**Policyholder** Sex: Female Male **Policyholder** Phone: \_\_\_\_\_

**Policyholder** Employer: \_\_\_\_\_

**Policyholder** Occupation: \_\_\_\_\_

**Policyholder** Employment: Part-Time Full-Time

## SECONDARY INSURANCE

Name of Primary Insurance: \_\_\_\_\_

**Policyholder** Name: \_\_\_\_\_

Your Relationship to Policyholder: Self Spouse Parent Other: \_\_\_\_\_

**Policyholder** Date of Birth: \_\_\_\_\_

**Policyholder** Social Security: \_\_\_\_\_

**Policyholder** Sex: Female Male **Policyholder** Phone: \_\_\_\_\_

**Policyholder** Employer: \_\_\_\_\_

**Policyholder** Occupation: \_\_\_\_\_

**Policyholder** Employment: Part-Time Full-Time

### MEDICARE Patients:

If **Medicare is secondary**, please check the reason below.

- Working Aged Beneficiary or Spouse with Employer Group Health Plan
- End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
- No-fault Insurance including Auto is Primary
- Worker's Compensation
- Public Health Service (PHS) or Other Federal Agency
- Black Lung
- Veteran's Administration
- Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
- Other Liability Insurance is Primary

***IF YOU HAVE A TERTIARY INSURANCE, PLEASE USE A SEPARATE SHEET AND INCLUDE INFORMATION ABOVE. THANK YOU!***

***Office Staff - Scan as INSURANCE UPDATE FORM document type***



**SLEEP DISORDERS CENTER OF VIRGINIA**

Martin F. Betts, M.D.  
Kathe G. Henke, Ph.D.  
Suleman H. Iqbal, M.D.  
Richard A. Parisi, M.D.

**PLEASE FILL OUT THESE FORMS AND BRING THEM TO YOUR FIRST VISIT.**

Date Completed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name: \_\_\_\_\_

Current Marital Status: Single Married Separated Divorced Widowed Partnered

List the ages of your children: \_\_\_\_\_

Did a physician send you to our office, or did you come on your own? Self-Referred Physician Referred

Which physician referred you?

Name: \_\_\_\_\_  
Specialty: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Who is your primary care physician?

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

*\*Missing or incorrect referring and primary care physician information could delay your reports\**

**Please describe your main sleep problem.**

\_\_\_\_\_  
\_\_\_\_\_

**How long have you had this problem? Check One**

- Less than 1 month  More than 6 months
- 1-3 months  1 year or more
- 3-6 months

**How often do you experience this problem?**

- 1-2 times per week
- 3-5 times per week
- Almost every night

Yes No Have you and your bedpartner had to sleep separately due to these issues?  
If yes, for how long? \_\_\_\_\_

**Is this problem...** getting better staying the same getting worse

Yes  No Have you had prior sleep studies or evaluations for a sleep disorder?

Yes  No Have you received any prior treatments for a sleep disorder?

**If yes, please describe any studies or treatments you have received. If possible, please bring a copy of these records with you to your first appointment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Office Staff - Select NP PACKET document type*

Occupation: \_\_\_\_\_

**Do you work shift work?**  Yes  No  
If yes, what shift?  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  
 Swing (please describe): \_\_\_\_\_  
 Variable (please describe): \_\_\_\_\_

**What is your bedtime?** \_\_\_\_\_ p.m. / a.m.  
How long does it take you to go to sleep? \_\_\_\_\_ min / hours  
How many times do you awaken during the night? \_\_\_\_\_  
What time do you get up on work days? \_\_\_\_\_ a.m. / p.m.  
What time do you get up on days off? \_\_\_\_\_ a.m. / p.m.  
How many times do you get up to use the bathroom at night? \_\_\_\_\_

**Are you most comfortable sleeping...**

\_\_\_\_\_ On your side?  
\_\_\_\_\_ On your back?  
\_\_\_\_\_ On your stomach?  
\_\_\_\_\_ In bed with your head elevated?  
\_\_\_\_\_ In a chair or recliner?

**How do you feel when you wake up from regular sleep time?**

Rested  Same as at bedtime  Tired  
 Y  N Do you nap or doze during the day? \_\_\_\_\_ How long is your nap in the AM?  
 Y  N Are any of these naps unintentional? \_\_\_\_\_ How long is your nap in the PM?  
 Y  N Are these naps intentional?

**If you nap or doze during the day, how do you feel when you awake?**

Rested  Same as at bedtime  Tired

**Recently, how many times per week are you or your bed partner bothered by the following symptoms?**

	# Times per Week		# Times per Week
<input type="checkbox"/> Loud or explosive snoring	_____	<input type="checkbox"/> Sleep walking	_____
<input type="checkbox"/> Awaken gasping	_____	<input type="checkbox"/> Nightmares	_____
<input type="checkbox"/> Awaken choking	_____	<input type="checkbox"/> Bedwetting	_____
<input type="checkbox"/> Twitching sensation of limbs	_____	<input type="checkbox"/> Teeth grinding	_____
<input type="checkbox"/> Stop breathing while asleep	_____	<input type="checkbox"/> Heartburn at night	_____
<input type="checkbox"/> Morning headaches	_____	<input type="checkbox"/> Esophageal reflux, or bitter taste in throat when you wake	_____
<input type="checkbox"/> Difficulty falling asleep	_____	<input type="checkbox"/> Awakening with dry mouth	_____
<input type="checkbox"/> Difficulty staying asleep	_____	<input type="checkbox"/> Awakening with stuffy nose	_____
<input type="checkbox"/> Difficulty returning to sleep after awakening	_____	<input type="checkbox"/> Wake yourself with your own snoring	_____
<input type="checkbox"/> Waking up too early	_____		
<input type="checkbox"/> Getting too little sleep	_____		

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**Answer the following to the best of your ability.**

- Y  N Just as you are dozing off or immediately upon awakening, do you ever hallucinate (hear, see or feel things that are not real)?
- Y  N Do you ever feel paralyzed for a few seconds as you awaken?
- Y  N Do you frequently lose track of what you are doing during routine activities, such as driving through stop signs or missing freeway exits?
- Y  N Do you have any restless, non-painful feelings in your legs at night?
- Y  N Do you have an itching or crawling sensation in your legs when you lie down to sleep?
- Y  N Do you experience any leg or hip pain during the night?
- Y  N Do you wake up with sore or aching muscles or joints?
- Y  N Have you been diagnosed with any neurological disorder?
- Y  N Have you ever had spinal surgery?
- Y  N Have you been or are you being treated for chronic pain?

**Do you or have you ever experienced episodes of muscle weakness, loss of muscle strength or limp muscles in any part of your body during the following situations?**

- Y  N When you laugh?
- Y  N When you are angry?
- Y  N When hearing or telling a joke?

**How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you have not done some of these things recently, try to think how they would affect you. Use the following scale to choose the *most appropriate answer* for each situation.**

Situation	would never doze	slight chance of dozing	moderate chance of dozing	high chance of dozing
Sitting and reading	___0	___1	___2	___3
Watching TV	___0	___1	___2	___3
Sitting, inactive in a public place (e.g. in a theater or meeting)	___0	___1	___2	___3
As a car passenger for an hour without a break	___0	___1	___2	___3
Lying down to rest in the afternoon when circumstances permit	___0	___1	___2	___3
Sitting and talking with someone	___0	___1	___2	___3
Sitting quietly after a lunch without alcohol	___0	___1	___2	___3
In a car, while stopped for a few minutes in traffic	___0	___1	___2	___3

**Caffeine**

- # Cups/servings of coffee per day? \_\_\_\_\_
- # Cups/servings of tea per day? \_\_\_\_\_
- # Cups/servings of caffeinated Soft drinks per day? \_\_\_\_\_

**Alcohol**

- Y  N
- Y  N
- Y  N

- Do you drink alcohol (including beer)?
- Are these primarily consumed after 7:00 p.m.?
- Do you drink alcohol to aid with sleep?
- How many drinks per week do you consume?

**Sleep Aids**

- Y  N Do you use any other drugs or medications to aid with sleep?
- \_\_\_\_\_ How many times per week to you use these?

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**Tobacco**

Y  N Do you currently smoke cigarettes?  
 Y  N Do you get up to smoke at night?  
 Y  N Have you ever smoked cigarettes?  
\_\_\_\_\_ How many packs per day?  
\_\_\_\_\_ For how many years?  
\_\_\_\_\_ When did you quit?

**Weight**

How much weight have you gained in the past year? \_\_\_\_\_ lb.  
How much weight have you gained in the past 5 years? \_\_\_\_\_ lb.  
 Y  N Has your neck or shirt collar size increased recently?  
\_\_\_\_\_ If yes, by how many inches?

Y  N Do you use recreational drugs? Type: \_\_\_\_\_ How often? \_\_\_\_\_

How many days a week do you usually get at least 30 minutes of physical exercise? \_\_\_\_\_

**LIST OF YOUR CURRENT PRESCRIPTION MEDICATIONS**

NAME	DOSE SIZE	HOW OFTEN	REASON FOR MEDICATION	MONTHS ON MEDICATION

**LIST OF YOUR CURRENT OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS**

NAME	DOSE SIZE	HOW OFTEN	REASON FOR MEDICATION	MONTHS ON MEDICATION

**Please list any allergies.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Write in the names and years of any operations which you have had.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had tonsils removed or surgery to your nose or sinuses?  Y  N

**Have you ever had any of the following problems?**

**Respiratory**

Asthma or Emphysema  Y  N  
Choking or gasping at night  Y  N  
Coughing spells at night  Y  N  
Periodic shortness of breath  Y  N

**Cardiovascular**

Heart disease  Y  N  
Angina or chest pains  Y  N  
High blood pressure  Y  N  
Fainting or feeling faint  Y  N  
Racing heart or irregular heart beat  Y  N  
Swelling in your legs, ankles or feet  Y  N

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**Ear Nose Throat**

- Stuffy nose or congestion  Y  N
- Sinus problem  Y  N
- Sour taste in mouth  Y  N
- Swallowing pain or problem  Y  N

**Musculokeletal**

- Arthritis  Y  N
- Numbness or tingling  Y  N
- Leg pains or cramps  Y  N

**Urological**

- Problem controlling urination  Y  N
- Kidney dysfunction  Y  N
- Frequent nocturnal urination  Y  N
- Varying menstruation cycles  Y  N
- Post menopause or Hysterectomy  Y  N
- Prostate problems  Y  N

**Neurological**

- Stroke or Cerebrovascular Accident (CVA)  Y  N
- Loss of consciousness  Y  N
- Seizures, fits, or convulsions  Y  N
- Dizziness  Y  N
- Decreased or worsening memory  Y  N
- Decreased concentration ability  Y  N
- Hallucinations or delusions  Y  N

**Endocrine System**

- Intolerance to hot or cold  Y  N
- Thyroid problems  Y  N
- Diabetes  Y  N
- Blood sugar problems  Y  N

**GI**

- Acidic taste in throat at night  Y  N
- Heart burn  Y  N
- Change in appetite  Y  N

**Psychological**

- Panic attacks  Y  N
- Alcohol or drug problems  Y  N
- Crying episodes  Y  N
- Severe anxiety or nervousness  Y  N
- Increased moodiness  Y  N
- Suicidal thoughts  Y  N
- Suicide attempt  Y  N
- Loss of usual interests  Y  N
- Depression  Y  N
- Decreased sexual drive or ability  Y  N
- Nervousness  Y  N

Y  N **Have you ever had a concussion, brain injury, or serious blow to the head?**  
If yes, when? \_\_\_\_\_

Y  N **Have you ever been treated for cancer?**

**Do you know of any blood relative who has or had any of the following?**

- Y  N Narcolepsy
- Y  N Loud snoring
- Y  N Sleep Apnea
- Y  N Restless Legs Syndrome
- Y  N Excessive daytime sleepiness
- Y  N Goiter or thyroid disease
- Y  N Epilepsy or seizures
- Y  N High blood pressure
- Y  N Asthma or emphysema
- Y  N Migraine headaches
- Y  N Heart attack
- Y  N Congestive heart failure
- Y  N Insomnia
- Y  N Stroke
- Y  N Diabetes
- Y  N Kidney disease

**Specify relationship to you**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Who can we contact in case of emergency:**

Name: \_\_\_\_\_ Relationship to You: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Nighttime Phone: \_\_\_\_\_

*Office Staff - Scan as NP PACKET document type*

## BEDPARTNER QUESTIONNAIRE

This portion of the form should be filled out by someone, **other than yourself**, who knows your sleep habits well – a spouse, family member, significant other, etc.

Name of person completing this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

1. I have observed this person's sleep:  never  once or twice  often  almost every night

2. Check any of the following behaviors that you have observed the patient doing ***while asleep***. Circle those that you consider severe.

- |   |  |
|---|--|
| <input type="checkbox"/> light snoring  | <input type="checkbox"/> loud snoring                  |
| <input type="checkbox"/> loud snorts  | <input type="checkbox"/> choking                       |
| <input type="checkbox"/> pause in breathing for _____ seconds                 | <input type="checkbox"/> gasping for air               |
| <input type="checkbox"/> twitching or kicking of legs                         | <input type="checkbox"/> twitching or flinging of arms |
| <input type="checkbox"/> sleep talking  | <input type="checkbox"/> grinding teeth                |
| <input type="checkbox"/> bed-wetting  | <input type="checkbox"/> sitting up in bed not awake   |
| <input type="checkbox"/> awakening with pain                                  | <input type="checkbox"/> head rocking or banging       |
| <input type="checkbox"/> getting out of bed not awake                         | <input type="checkbox"/> biting tongue                 |
| <input type="checkbox"/> becoming very rigid and/or shaking                   | <input type="checkbox"/> crying out                    |
| <input type="checkbox"/> apparently sleeping even if he/she behaves otherwise | <input type="checkbox"/> other: _____                  |

3. If this person snores, what makes it worse?

- sleeping on his/her back  sleeping on his/her side  alcohol  fatigue

4. Does the snoring sometimes require you and your partner to sleep separately?  yes  no

5. Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

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6. Has this person ever fallen asleep during normal daytime activities or in dangerous situations?  yes  no  
If yes, please explain.

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7. Does this person use sleeping pills?  yes  no  
If yes, how many per week?  less than 1 per week  1-3 per week  
 4-7 per week  7 per week

8. Do you consider this usage a problem?  yes  no

Comments: \_\_\_\_\_  
\_\_\_\_\_

PLEASE CONTINUE BEDPARTNER QUESTIONNAIRE ON NEXT PAGE

***Office Staff - Scan as NP PACKET document type***

**BEDPARTNER QUESTIONNAIRE – page 2**

This portion of the form should be filled out by someone, **other than yourself**, who knows your sleep habits well – a spouse, family member, significant other, etc.

9. Does this person drink alcohol?  Y  N  
If so, what type?  beer  wine  shots  
Estimate their use of alcohol per week:  
\_\_\_\_\_ # of 12 oz. beers  
\_\_\_\_\_ # of 6-8 oz. glasses of wine  
\_\_\_\_\_ # of 1-1 ½ oz. liquor

10. Estimate how much this person drinks three hours before bed. \_\_\_\_\_

11. Do you consider this person’s drinking a problem?  Uncertain  Yes  No  
Comments: \_\_\_\_\_

12. If this person uses street drugs, please describe the type and frequency of usage.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Do you believe that you both share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage?  Yes  No

14. Other comments are welcome.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Office Staff - Scan as NP PACKET document type***

**Consent for Purposes of Treatment, Payment and Healthcare Operations**

Dear Patient,

In accordance with the **Health Insurance Portability and Accountability Act (HIPAA) of 1996**'s Privacy Standards, Sleep Disorders Center of Virginia asks you to carefully read your rights below.

**What is Protected Health Information?**

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

**For what purposes will my Protected Health Information be used?**

This information is used for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

**Your right to request restriction of your Protected Health Information.**

I have the right to request a restriction on how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioners of Sleep Disorders Center of Virginia are not required to agree to the restrictions that I may request. However, if Practitioners agree to a restriction at my request, the restriction is binding on Sleep Disorders Center of Virginia.

**Notice of Privacy Practices**

I have a right to review Sleep Disorders Center of Virginia's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes in more detail the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Sleep Disorders Center of Virginia. It describes my rights and the Sleep Disorders Center of Virginia's duties with respect to my protected health information. This Notice of Privacy Practices is available to me at the front desk of Sleep Disorders Center of Virginia.

Sleep Disorders Center of Virginia reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices at any Sleep Disorders Center of Virginia location.

**Consent**

I consent to the use or disclosure of my protected health information by practitioners of Sleep Disorders Center of Virginia. I understand that diagnosis or treatment to me by practitioners of Sleep Disorders Center of Virginia may be conditioned upon my consent.

\_\_\_\_\_  
SIGNATURE of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINT Name of Patient or Personal Representative

\_\_\_\_\_  
Date

***Office Staff – Scan as HIPAA FORM***

## FINANCIAL POLICY

Welcome and thank you for choosing our facility for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our fees have been determined through careful consideration in addition to being reasonable and customary with our geographical area. It is the patient responsibility to verify benefits with their health insurance carrier. Understand your eligibility, pre-existing condition limitations, co-pay, co-insurance, deductible and all “out of pocket” expenses. We contract with your insurance company and we are obligated to collect all balances.

Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa and MasterCard. We also provide our patients the ability to pay for their accounts online at [www.sleepcenter.org](http://www.sleepcenter.org) or over the phone at (804) 521-0568.



Billing Office Hours are:

- Monday – Friday 7AM to 4 PM
- Our voicemail is available 24 hours a day, 7 days a week

Things to bring with you to EACH appointment:

- Health Insurance Card
- Drivers License
- Method of Payment
- Referral if needed

Appointments:

- Please arrive for your appointment 15 minutes early.
- If more than 15 minutes late for your appointment, you may be marked as a *No Show* and will need to reschedule your appointment at another time.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals **BEFORE** your scheduled appointment. (Failure to confirm this will result in your responsibility for any and all charges.)
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage will result in you being responsible for any services not covered by your insurance carrier.

Missed or Cancelled Appointments and other fees:

- If you are more than 15 minutes late for an appointment, you may be marked as a *No Show*. Failure to show for your office appointment will result in a \$35.00 fee, your night study appointment a \$200.00 fee.
- 24 hours notice is required to cancel and reschedule all appointments. Failure to do so may result in a \$25.00 *No Show* office appointment fee or a \$200 *No Show* fee for a night study appointment.
- There will be a fee of \$30.00 for any returned checks.
- All balances are due prior to any further service provided by our office.
- Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan.

Medical Equipment:

- If you are a patient who has received sleep therapy equipment through our CTS (CPAP Therapy Services) division, you are reminded that all equipment that is rented remains the property of Health Consultants of Virginia, Inc. until the equipment is purchased.
- Each insurance company is unique in their requirements to reimburse your costs of rental or purchase of equipment. It is your responsibility to verify benefits with your health insurance carrier. Understand your eligibility, pre-existing condition limitations, co-pay, co-insurance, deductible and all “out of pocket” expenses.
- As a condition of payment for your equipment, your health insurance company may require that you return to this office for a follow-up appointment. The insurance company may also require a download of data from your machine before they will pay for the purchase of the equipment. Each patient is responsible for making sure these requirements are met. If these requirements are not met, you may be responsible in full for all charges associated with your equipment.

**PATIENT COPY**



**FINANCIAL POLICY ACKNOWLEDGEMENT**

It is the patient's responsibility to verify benefits with their health insurance carrier. Understand your eligibility, pre-existing condition limitations, co-pay, co-insurance, deductible and all "out of pocket" expenses. We contract with your insurance company and we are obligated to collect all balances.

By signing this document, I, \_\_\_\_\_, have received the financial policy of Health Consultants of Virginia, Inc. (dba Sleep Disorders Center of Virginia). I hereby consent to allow this practice to reach me via: (check all that apply)

- Home phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_
- Cell phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_
- Work phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_
- Text: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_
- Email : \_\_\_\_\_ @ \_\_\_\_\_

And understand and consent to this practice using an automatic dialer to reach me. I will cooperate with the billing department to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. This includes any legal fees and/or court costs. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

\_\_\_\_\_  
Printed name of patient/parent/guardian

\_\_\_\_\_  
Signature of patient/parent/guardian (SEAL)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

PLEASE RETURN SIGNED DOCUMENT TO THE FRONT DESK.  
A COPY WILL BE GIVEN TO YOU.

**Office Staff – Scan as FINANCIAL POLICY**