Health & Wellness

The Sleep Institute

Idaho's home for leading-edge sleep care – and a good night's rest

Cynthia M. Rice RNC, NP
Nurse Practitioner

Bradford L. Talcott, PhD, MD
Board Certified Sleep Specialist
Medical Director

Helene Poulos-Edmo, DNP, FNP-C
Nurse Practitioner

Phone: 208-233-9355
Fax: 208-233-9300

Accredited by The American Academy of Sleep Medicine

1553 E. Center St.
Pocatello, ID 83201

Please fill out all packet information

How did you hear about our services? ___ **Newspaper** ___ **Television** ___ **Radio** ___ **Phone Book** ___ **Referral (friend / relative / provider)** ___ **Other**

PERSONAL INFORMATION:

Last Name: ______________ First: ______________ Mailing Address: ________________________ City: ___________ State: _____

Zip: _______ Home #: (____) ___________ Cell #: (____) __________ Work #: (____) ____________ Other #: (____) ____________

Birth Date: ___/___/___ Current Age: _____ Social Security #: ______ - ______ - _______ Email: ______________________________

Sex: F / M Married___ Single ___ Other ___ Employer Phone #: (___) ____________ Employer: ____________________________

EMERGENCY CONTACT: **(Name of person not living with you)**

Last Name: ________________ First: ______________ Address: ____________________________ City: ___________ State: _____

Zip: _______ Home #: (____) ___________ Cell #: (____) __________ Work #: (____) ____________ Other #: (____) ____________

Relationship to patient: ____

PARTY RESPONSIBLE FOR BILL:

Last Name: ________________ First: ______________ Address: ____________________________ City: ___________ State: _____

Zip: _______ Home #: (____) ___________ Cell #: (____) __________ Work #: (____) ____________ Other #: (____) ____________

Employer Phone #: (___) ____________ Employer: ____

INSURANCE INFORMATION:

Primary Insurance Company: ______________________ Policy #: ______________________ Group #: _________________

Policy Holder: _________________________ Birth Date: _____________ Policy Holder Social Security # __________________

Secondary Insurance Company: ______________________ Policy #: ______________________ Group #: _________________

Policy Holder: _________________________ Birth Date: _____________ Policy Holder Social Security # __________________

I consent to treatment by Health & Wellness Sleep Institute and staff and **I agree to pay all fees and charges regardless of insurance coverage**. I consent to the release of medical and financial information to my insurance company and authorize them to make payments directly to Health and Wellness Sleep Institute or any billing agent acting in their behalf, to release any information necessary to process any claim on my behalf. **If my account is turned to collections, there will be a $50.00 administrative fee added.** A copy of this form shall be as valid as the original.

Patient Signature: ____ **Date:** ________________________

Medicare (if applicable): I request that payment of authorized Medicare benefits be made either to me or on my behalf to Health & Wellness Sleep Institute for any services furnished to me by that supplier. I authorize any holder of medical information about me to be released to the HCFA and its agents for any information needed to determine these benefits payable to related services. **If my account is turned to collections, there will be a $50.00 administrative fee added.** A copy of this form shall be as valid as the original.

Patient Signature: ____ **Date:** ________________________

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We are dedicated to providing our patients with the best possible care and service, at the most reasonable price. Your understanding of our financial policies is essential. To assist you, we have instituted the following financial policy. If you have questions, please feel free to discuss them with our billing staff. **Unless other arrangements have been approved in advance, full payment is due at the time of service with the exception of sleep studies.** For your convenience, we accept Visa and MasterCard.

Your Insurance: **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. As a courtesy**, we will file your Primary insurance claim for you. If your insurance company does not respond or pay within a reasonable length of time (30 days), you will be expected to pay the account in full and to contact your insurance company for reimbursement. All charges are your responsibility from the date that services are rendered, regardless of insurance coverage.

Some insurance companies require a referral or pre-certification/pre-authorization. We will gladly assist you in meeting these requirements when requested. However, the responsibility is yours to ensure that such requirements are completed. As a patient in our office, it is your responsibility to inform us of any changes on your account regarding demographic and insurance information.

Medicaid: All Medicaid recipients must present their Medicaid Card at the time of service. Any Medicaid recipient who has a Healthy Connections provider must see that provider first and MUST obtain a Healthy Connections referral before being seen at our practice. Patients that do not have a referral will be considered to have no insurance and full payment will be expected at the time of service. Missed Appointments policy (listed below) will also apply to Medicaid Recipients.

Minor patients are offered all services; the adult accompanying the patient is responsible for payment. All returned checks will be subject to an additional collection fee, ($25.00). Cash or cashier check required.

Missed appointments: As soon as you become aware that you will not be able to keep a scheduled appointment, notify our office to reschedule. We do have an answering machine to allow for "anytime messages". As a courtesy, we call to remind you of your appointment two days prior. We do reserve the right to charge a $26.00 appointment fee for repeated missed, confirmed appointments. If you miss 3 appointments, we reserve the right to terminate you as a patient.

Collections: **If your account balance is delinquent and no attempt has been made to contact our office with financial arrangements, your balance will be reviewed and possibly referred to a collection agency. We would rather work with you. If your account is turned over to a collection agency, you will be required to pay for appointments in full at the time of service and there will be a $50.00 administrative fee added to your account.**

The ultimate responsibility for your medical bill incurred at our practice lies with you, our patient, NOT your insurance or third party payer. I have read, and fully understand the financial policy of the practice and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by the practice.

Patient Signature:______________________________ **Date:**______________

Patient Printed Name:______________________________________

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Written Acknowledgement of the Receipt of the Notice of Privacy Practices and Patient Disclosure

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communication or that a communication of protected health information is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

☐ I acknowledge that I have been offered and/or have read a copy of the Notice of Privacy Practices. I also understand that a copy is available to me upon request.

I wish to be contacted in the following manner (check all that apply)

Home Telephone ____________ **Cell #** ___________________
☐ O.K to leave message with detailed information ☐ Leave message with call back number only
Work Telephone ______________
☐ O.K to leave message with detailed information ☐ Leave message with call back number only
Written Communication
☐ O.K. to mail to my home address ☐ O.K. to mail to my work/office address ☐ O.K. to fax to this number ______________
Release to Other
☐ O.K. to release information to (name) _________________
☐ Do not release information to spouse/significant other
Relationship to patient ___________________

Date: __________ Print Patient Name: ____________________

Patient Signature: _____________________ Witness Signature: ___________________

For your information video surveillance is in use at all times for your safety and security.

PATIENT CONSENT

I authorize The Health & Wellness Sleep Institute to use my personal health information for the purpose of treatment, payment and healthcare operation. My information will only be used for the following purposes:
* For treatment to another provider for consultation about a diagnosis or treatment or if we need to refer you to another provider.
* To submit a claim for payment of services prided to you, including any information requested by the insurance company.
* If we need your personal health information to conduct health care operations and administrative functions at our facility. These would include: Accreditation/certification activities, legal service, auditing functions, quality assessment and studies, compliance programs, training of health care professionals and providers, review the qualifications of the health care professionals and providers.

Patient Signature: ____________________________________ **Date:** ___________________________

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MEDICAL INFORMATION AND HISTORY

OCCUPATION: ______________________ Current Primary Care Clinic/Physician: ______________________

Reason for visit: ______________________ Who referred you? ______________________

Symptoms you would like to discuss: ______________________

Please list all medical problems you see other Health Care Providers for: ______________________

____

____

List ALL overnight hospitalizations, surgeries, or procedures: Please include dates. ______________________

____

List ALL MEDICATIONS, INCLUDING, natural herbs, supplements, alternative therapies, vitamins, and/or over the counter treatments, such as, Tylenol PM, Advil, allergy medications, weight loss supplements, that you CURRENTLY take or are prescribed:

____

____

____

Please list ALL prescribed medications and/or over the counter or alternative treatments **you have used in the past 5 years:** ______________________

____

PLEASE LIST ALL DRUG/FOOD ALLERGIES: ______________________

Check all that apply to you past or present and for any **blood relative**:

Self	Relative		Self	Relative		Self	Relative		Self	Relative	
O	O	Weight fluctuations	O	O	Stroke/TIAs	O	O	Arthritis/Myalgias	O	O	Mental Illness
O	O	Migraines/headaches	O	O	High cholesterol	O	O	Osteopenia/Osteoporosis	O	O	Anxiety/Depression
O	O	Epilepsy/Convulsions	O	O	Heart Valve Disorder	O	O	Bleeding Disorder	O	O	Sleep Problem
O	O	Thyroid problems	O	O	Lung /Asthma/Allergies	O	O	Blood Transfusion			If yes, C-PAP yes ___ no ___
O	O	Infertility	O	O	Stomach Ulcer/Reflux	O	O	Cancer			
O	O	Angina-Chest pain	O	O	Bowel Problems	O	O	Anemia/Low iron			Please list others if not listed:
O	O	Heart Attack	O	O	Liver/Hepatitis/Hep C	O	O	Diabetes/Insulin Resistance			______________
O	O	High blood pressure	O	O	Neurological/RLS	O	O	Alcoholism/Substance abuse			______________

Do you use tobacco Yes / No If yes, How long did you use tobacco ________ When did you quit ________.

Do you drink alcohol Yes / No If yes, How often ________ Usual amount ______________.

Do you use caffeine Yes / No How many ounces do you drink each day? ______________.

Do you use street substances Yes / No Have you used in the past Yes / No. If yes, what kind ______________

When was your last: Blood Test: ____ Colonoscopy:_____ Endoscopy:_____ Flu vaccine:______ Pneumonia vaccine:______ Pertussis vaccine:______ Tetanus vaccine:______ Mammogram: ________ Female Pap smear:_______ Female Pelvic Exam: ________ Male Prostate exam: ________

Abnormal results: Mammograms: Yes / No When________. PAP smear: Yes / No When_______. Female Colposcopy: Yes / No When ______.

Are you pregnant or plan on getting pregnant? __________. When was your last menstrual period? __________.

Pregnancy History: Number of pregnancies ________. Number of live births __________. Years of deliveries ______________.

What form of contraception are you using (circle): Condoms Sterilization (self/partner) Pills IUD Ring Patches Abstinence or Other

PATIENT NAME ______________________ D.O.B. __________ AGE _____ TODAY'S DATE__________

Weight Loss Consult Form for Patient to complete prior to interview/evaluation

Name:

Date completed:

Reasons you want to lose weight:

Current Weight:

Goal Weight:

When was the last time you were at your goal weight?

Did you diet or exercise to achieve that weight? What did you do?
What was your weight prior?

Your weight history:

What did you weigh, when in high school? At age 21? At age 31? At age 51?

List other times your weight fluctuated. (example pre-pregnant & delivery weight) Did you lose all the weight after pregnancy prior to the next pregnancy?

List other times your weight changed: (physical injury, medical problem, life change/stress/job/marriage)

Please outline a daily routine. Use an average ordinary day, not an exceptional good or bad day.

What time do you get out of bed? What is the first thing you eat or drink? What is that?

What do you do next? What and when do you eat or drink next?

Time: Beverage or food:

Do you tend to snack throughout the day? Do you usually have three times a day that you eat?

In a typical week, how many times do you get your food or beverage from a convenience store, deli or restaurant? Including take out, delivery, drive through and sit down restaurants.

How many times a week do you prepare or cook your food from home?

How many times a week is your meal/food eaten at home?

Are you eating in your car? On the run? At your desk or job site?

Where else do you eat?

When you have tried to lose weight in the past, what have you done?

What happens? Are you too hungry? Do you have cravings?

What do you crave or typically struggle with that you feel interferes with being able to stay on a weight loss plan?

Are you feeling poorly? Lacking the energy or motivation to make behavior changes?

Do you dislike "diet foods"? Which ones?

Do you struggle with sleep? Sleep too much? Sleep too little? Eat during the night?

Activity level: How many hours a day at a desk or computer? How many hours a day watching TV or spectator? How many hours a day in the car/riding or driving? How many hours a day on your feet with work or chores? How many hours at the gym, or exercising?

Do you have hobbies? What do you do for fun/enjoyment? TV, computer, gaming, reading, social media, crafting, gardening, socializing in person, recreation, spectator, shopping physically or on line, gambling,

What do you do with your time:

Would you like to change how you use your time? If so, how and why?

Do you have symptoms of metabolic syndrome? Fatigue, depression, excessive appetite, anxiety, high blood pressure, low HDL cholesterol, slightly elevated blood sugar, high insulin levels, excess belly fat, changes in hormone levels, dark skin patches (neck, axilla, folds), skin tags, PCOS, sleep apnea.

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire

During the past week, I have found that:	Disagree ⟵					⟶ Agree	
1. My motivation is lower when I am fatigued.	1	2	3	4	5	6	7
2. Exercise brings on my fatigue.	1	2	3	4	5	6	7
3. I am easily fatigued.	1	2	3	4	5	6	7
4. Fatigue interferes with my physical functioning.	1	2	3	4	5	6	7
5. Fatigue causes frequent problems for me.	1	2	3	4	5	6	7
6. My fatigue prevents sustained physical functioning.	1	2	3	4	5	6	7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1	2	3	4	5	6	7
8. Fatigue is among my three most disabling symptoms.	1	2	3	4	5	6	7
9. Fatigue interferes with my work, family, or social life.	1	2	3	4	5	6	7
Total Score:							

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your level of fatigue. It's simple: Add all the numbers you circled to get your total score.

The Fatigue Severity Scale key

A total score of less than 36 suggests that you may not be suffering from fatigue.

A total score of 36 or more suggests that you may need further evaluation by a physician.

Your next steps

This scale should not be used to make your own diagnosis.

If your score is 36 or more, please share this information with your physician. Be sure to describe all your symptoms as clearly as possible to aid in your diagnosis and treatment.

Fatigue Severity Scale ©Lauren B. Krupp. Reproduced with permission from the author.

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Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

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

It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place—for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score:	

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate your own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get your total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness.

A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all your symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that true excessive daytime sleepiness is almost always caused by an underlying medical condition that can be easily diagnosed and effectively treated.

Epworth Sleepiness Scale ©MW Johns. Reproduced with permission from the author.

Mood Questionnaire

Instructions for patients: Please check ONE BOX ONLY for each of the questions below.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative and/or spoke much faster than usual?	☐	☐
...thoughts raced through your head and/or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active and/or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual—for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐

2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time?	YES	NO
	☐	☐

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Please discuss the results of this questionnaire with your physician.

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The Patient Health Questionnaire

Nine-symptom Checklist

Name________________________________ Date__________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed, or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself – that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
(For office coding: Total Score)	____	____	____	____

If you have experienced any of these problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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