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

Dr. James Pohl, 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:

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 $25.00 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_____

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PATIENT SLEEP/MEDICAL HISTORY

Date: _____

Patient Name: _____ ***Patient Date of Birth:*** _____

Referring Physician/Provider:_____ ***Primary Care Physician/Provider:***_____

What would you like to improve about your sleep?

1. _____
2. _____

Please take the time to complete this entire history form as completely as possible.
The more information we get, the more we can help.

EPWORTH SLEEPINESS SCALE (ESS)

Please score your chance of dozing in the following **routine daytime or routine awake time** circumstances:

SITUATION	CIRCLE YOUR SCORE BELOW
A. Sitting and Reading	0- 1- 2- 3
B. Watching Television, listening to radio, music	0- 1- 2 -3
C. Sitting, inactive in a public place (ie, meeting, theater, church)	0 -1 -2 -3
D. As a passenger in a moving vehicle for an hour without a break (ie, car, bus, taxi)	0- 1-2 -3
E. Lying down to rest in the afternoon when circumstances permit	0 -1-2 -3
F. Sitting and talking to someone, friends, or family	0 -1- 2 -3
G. Sitting quietly after lunch when you have had no alcohol	0- 1- 2- 3
H. In a car, while stopped in traffic (ie, does car behind you honk their horn for you to go on a Green Light?)	0- 1- 2- 3

CHANCE OF DOZING
HOW TO SCORE-SEE BELOW
0=Would Never Doze
1=Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

TOTAL SCORE:_____

Yes No Have you EVER been told you stop breathing at night?
Yes No Do you snore and/or have you EVER been told that you snore?
Yes No Do you move your arms, legs, or body much or have unusual behaviors during sleep?
Yes No Have you gained or lost weight in the last year **(please circle gained or lost)**? How much?
Yes No Do you have difficulty getting to sleep?
Yes No Difficulty staying asleep?
Yes No Do you fall asleep when you shouldn't or in dangerous situations?

What time do you usually go to bed? _____AM/PM What time do you usually get up? _____AM/PM
How long does it take you to fall asleep? _____
How many times do you wake up during a typical night's sleep? _____ WHY?_____
Do you take naps during the usual weekday?_____ What is the longest usual nap? _____

ALCOHOL, CAFFEINE, TOBACCO, OTHER:

How many caffeinated beverages of coffee, tea, cola, Mountain Dew, etc., do you have in a usual day?_____
Do you usually drink coffee, tea, cola, soda drinks within 2-5 hours of your bedtime? YES NO
How much alcohol do you drink daily? _____
How much tobacco/nicotine/chew/other do you use daily? _____

RESPIRATORY:

Yes No Do you have nasal obstruction, sinusitis, chronic nasal congestion or nasal discharge during sleep or when you awaken? If Yes, what's been tried to help?

Yes No Do you have shortness of breath, bothersome coughing, COPD, asthma, bronchitis, wheezing, trouble swallowing?

Yes No Are you or have you ever been on oxygen or a CPAP/BPAP/ASV device?

Do you smoke or chew tobacco? _____How many years? _____When did you quit?_____

PAIN:

Yes No Do you have pain during normal awake hours?

Yes No Does pain interfere with your sleep?

Yes No Do you see a Pain Specialist?_____ Whom?_____

Do you have headaches in the evening?_____ in the morning?_____ other times**?** _____

OTHER:

Yes No Do you have frequent, frightening dreams or nightmares?

Yes No Do you have vivid dreams, hallucinations/dream-like mental images during naps or awake times?

Do you lie awake at night feeling depressed, worried, anxious, tense, fearful, unhappy or disoriented? Yes No

Have you always been a "light sleeper?" Yes No Have you had months without insomnia? Yes No

Is your sleep environment Comfortable, Dark, Quiet, pleasant and Safe? If not, Please explain:_____

Yes No Do you have loss of interest in things that used to be of interest (hobbies, golf, friends, sex, etc…)?

Yes No Have you been interviewed by a psychiatrist or clinical psychologist?_____ Why?_____

Yes No Have you **EVER** attempted suicide or been admitted to a psychiatric hospital unit?

Yes No Have you **EVER** used meditation, acupuncture, hypnosis, biofeedback, or relaxation therapy to lower your tension level and help you to sleep?

Yes No **Men or Women:** Do you have problems with intimate partner relationships and performance?_____

Yes No Have you **EVER** been treated for migraines, meningitis, encephalitis, seizures, stroke, head trauma?_____

Yes No **Women: Are you pregnant?** Yes No **Women: Are you past menopause (change of life)?_____**

Please list any other current health problems & current medications: _____

_____

_____

YOUR CHILDHOOD SLEEP HISTORY:

Circle any of the following problems you had with your sleep as a child: bed wetting, sleep talking, sleepwalking, nightmares, night terrors screaming in sleep, grinding teeth/excessive snoring, head banging, falling asleep during school or activities, excessive sleepiness.

FAMILY HISTORY:

Yes No Does anyone else in your **biological family** have problems with sleep, medical, or psychiatric disorders? (This includes breathing problems, snoring, sleep paralysis, insomnia, excessive daytime sleepiness, sleepwalking, night terrors, sudden infant death syndrome, lung disease, bipolar disorder, mood disorders, diabetes, hypertension, etc.) _____

_____

SOCIAL HISTORY:

Circle the highest grade you completed in school: 7 8 9 10 11 12 13 14 15 16 17+

Academic/Technical Degrees/Diplomas:_____

Circle the response that best describes your present work: Employed? Self-employed? Laid-off? Dismissed from job?

Retired? Unemployed? Part-time/temporary job? Disabled? Other?_____

What is your present occupation?_____ Is your present occupation satisfying? Yes No

What is (or was) your spouse's/partner's occupation?_____

IS THERE ANYTHING ELSE WE SHOULD KNOW?

_____

ROOMMATE, BED-PARTNER OR FAMILY QUESTIONS

WE ASK THAT THE BED PARTNER/ROOM MATE OR FAMILY MEMBER ACCOMPANY THE PATIENT TO THEIR INITIAL APPOINTMENT(S) IF AT ALL POSSIBLE TO GET A MORE COMPLETE HISTORY.

Name of Patient:_____

I have observed this person's sleep: ____Never ___Once or Twice ____Often ____Every Night

Circle those that you have observed and consider **severe problems** for this person:

Light snoring, Loud snoring, Occasional loud snoring, Choking, Pause in breathing, Twitching or kicking of legs, Sleep talking, Grinding teeth, Bed-wetting, Sitting up in bed not awake, Awakening with pain, Head rocking or banging, Getting out of bed not awake, Biting tongue, Becoming very rigid and/or shaking, Crying out, Apparently sleeping even if he/she behaves otherwise, other?

If this person snores, what makes it worse? Sleeping on his/her back? Sleeping on his/her side? Alcohol/drugs? Other?

Has this person ever fallen **asleep** during normal awake time activities or in dangerous situations? Yes No

Does this patient exercise and what kind of exercise does this person do? How many days per week?_____

_____

Thank you for taking the time in filling out this page.

Signed:_____DATE:_____

Relationship to patient:_____