New Patient Sleep Packet

To our Patients,

We would first like to thank you for choosing West Coast Neurology as one of your health care providers. Providing you with the best possible experience is very important to us, and in order to do so we have created this packet to speed up the process once you step through our doors. Attached is paperwork on what to expect during your sleep study and how you should prepare for it. As well, there are waivers and a questionnaire to help the doctors get a deeper understanding of the problems you are having and how to better treat them. You can obtain more information about sleep disorders and what to expect during a test from our website at, www.WestCoastNeurology.com.

We pride ourselves in providing the highest level of service and care through every step of the process, including: testing, diagnosing, and treating sleep disorders at West Coast Neurology should you require treatment.

Please feel free to contact West Coast Neurology Pediatric and Adult Neurodiagnostic Center staff with any questions about your upcoming study.

Sincerely,

West Coast Neurology

Your appointment is scheduled for:

Date: _____ TIME: _____

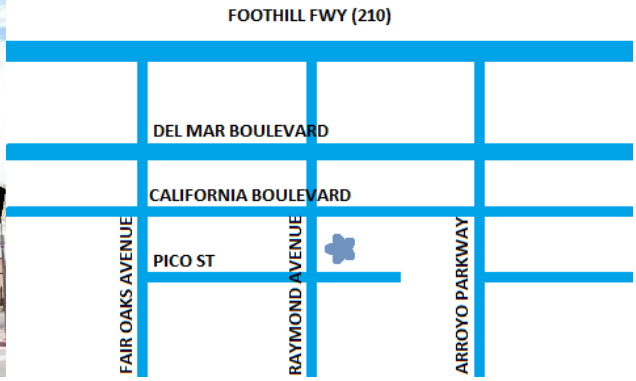
West Coast Neurology, Inc.
Pediatric and Adult Neurodiagnostic Program

630 S Raymond Ave Suite 310, Pasadena, CA 91105 | Bus: (626) 598-3770 | Fax: (626) 598- 3797

You have been scheduled for a sleep study at the West Coast Neurology Pediatric and Adult Neurodiagnostic Center.

When you arrive:

The Technician will meet you in front of the gates to the parking garage (off Pico St.) at the time of your scheduled study. Please stay in your vehicle until your technician arrives to give you access to the parking garage. If your do not see your technician please call them at (626) 800-1235 to let them know you have arrived.



Location: 630 South Raymond Ave Suite 310 Pasadena CA 91105

Cross Streets: California Blvd between Fair Oaks Blvd and Arroyo Parkway

PATIENT INSTRUCTION SHEET

INSTRUCTIONS

- No caffeine after 9 am the day of the test
- Eat dinner before you arrive (we do have snacks and caffeine-free drinks)
- Bring your insurance card
- You may bring your own pillow although pillows and blankets will be provided.
- Bring comfortable clothing (NO SILK or SATIN)
- You hair should be clean and free of any styling products (i.e. gels, hairsprays, creams, etc.)
- Electrode gel will be used to adhere leads to your scalp
- Bring any medications you regularly take at night, including your sleep medications
- Departure time is around 6-7 am; please tell the technicians if you need to leave earlier

WHAT TO EXPECT

Upon your arrival you will be greeted by a technician who will escort you to your room. The technician will explain the procedure and what to expect during the night. Electrode gel will be used to adhere leads to lower legs, chest, head and face; this washes off easily with water. Wake up time is between 6 and 7 am.

ITEMS TO BRING FOR YOUR SLEEP STUDY

Please review the list below and feel free to ask our center team if you have any questions:

ITEMS TO BRING:

- Driver's License
- Insurance Card
- Medication
- Medication List
- Light Overnight Bag
- 2 Piece Pair of Pajamas
- Toothbrush\ Mouthwash
- Personal Hygiene Products

ITEMS & SERVICES WE PROVIDE

- Coffee/ Juice in the Morning
- Reading Lamp
- Registered Technicians
- Bi-Lingual Staff
- Private Room for your Caretaker (If Needed)
- Free Secured Parking
- Bathroom

DO NOT BRING:

- Valuable jewelry or large sums of money
- Strong Perfumes or Cologne
- Alarm Clock (we will wake you up)

Please let us know if you have any disabilities or special needs that we should know about prior to your study. Due to the gel we use to attach each lead, you will need to wash your hair following the study. If there is anything else we can do to make your stay more enjoyable, do not hesitate to ask. We want to provide you with the best experience possible!

Sincerely,

West Coast Neurology

Patient: _____

Last Name **First Name** **Middle Initial**

Cell Phone: _____ **Home Phone:** _____

Email: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: M ☐ **F** ☐ **Age:** _____ **Birth Date:** _____ **Height:** _____ **Weight:** _____

Occupation: _____ **Race/Ethnicity:** _____ **Language:** _____

Emergency Contact: _____

Relation: _____ **Contact Number:** _____

Referring Physician: _____

Patient Agreement	**Assignment and Release** **I, understand, have insurance coverage with _____, and assign directly to West Coast Neurology all medical benefits, if any. Otherwise payable to me for services rendered that I am financially responsible for all charges whether paid or not paid by insurance I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions.** **_____ _____** **Signature of insured/ Guardian** **Date**
Workers Compensation/Auto Insurance Information	****Only if Work/ Accident Related**** **Date of Injury: _____** **Insurance Company Name: _____** **Address: _____Phone: _____** **City: _____ State: _____ Zip:_____** **Adjuster: _____ Claim #: _____**

Notice of Privacy Practices

Our Assurance Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duties

The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your right regarding your medical information, as well as follow the terms of the current notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the change is permitted by law. We have the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

- **For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.
- **For Payment:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Additional Uses and Disclosures

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- **Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray , imaging or medical information for you.
- **Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

- **Research in Limited Circumstances:** We may use medical information for research or health survey purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
- **Funeral Director, Coroner, and Medical Examiner:** To help them carry out their duties, we may share the medical information, of a person who has died, with a coroner, medical examiner, funeral director, or an organ procurement organization.
- **Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
- **Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- **Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for the purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- **Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
- **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
- **Law Enforcement:** Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding

suspected victims of crimes at the request enforcement official, reporting death, crimes on our premises, in our presence, and crimes in emergencies.

- **Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of appointments. Including, but not limited to, voicemails of future appointment date and time.
- **Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You have the right to:

- Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request, unless it is not practical for us to do so. There may be charges for copying and for postage if you want copies mailed to you.
- Receive a list of all the times we and our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
- Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or different locations must be made in writing.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
- Please be aware that this notice does not necessarily catalog an exhaustive list of your rights. It is your responsibility to be aware of all your rights as pertaining to protected health information.

Questions and Complaints

If you have any questions about this notice, please send us written correspondence. If you think that we have violated your privacy rights, you may speak to the Privacy Officer and submit a written complaint.

I hereby acknowledge that I received a copy of the Notice of Privacy Practices, and I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I fully understand and accept the terms of this Notice of Privacy Practice, pages 1-3.

_____	_____	_____
Patient Name	Patient Signature (or responsible party, if minor)	Date

Patient Consent to Treatment and Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations (HIPAA)

I understand that as part of my health care, this organization named above originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. In regards to sleep studies and electroencephalogram (EEG) studies, I understand that digital videotapes, and photographs will be recorded to document my care, and I consent to this. I understand that the information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple health care provider who may be involved in the treatment directly and indirectly,
- obtain payment from third party payers, and
- conduct normal health care operations such as quality assessments and physician certifications. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. This organization reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that I have the following rights and privileges:
  - The right to review and receive a printed copy of this notice prior to signing this consent,
  - The right to inspect and copy, amend, or submit correction to, my protected health information,
  - The right to receive confidential communications about your medical condition and treatments, and
  - The right to request restrictions as to how my health information may be used or disclosed.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions. See Notice of Privacy Practices for more details.

I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I understand that as part of this organizations treatment, payment, or heath care operations, it may become necessary to disclose my protected heath information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax, email, phone, voice.

I fully understand and accept the terms of this consent and I hereby acknowledge that I received and a copy of the Notice of Privacy Practices, and I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name	Patient Signature (or responsible party, if minor)	Date

SLEEP QUESTIONNAIRE

PLEASE COMPLETE IN BLUE OR BLACK INK

The following questionnaire is designed to help aid our sleep specialist in providing the best care possible. We ask that you please answer all questions as accurately as possible; even if they do not pertain to you specific individual case.

PLEASE COMPLETE THE QUESTIONNAIRE BEFORE YOUR APPOINTMENT.

THANK YOU.

West Coast Neurology, Inc.

Pediatric and Adult Neurodiagnostic Program

Patient's Sleep History	
Have you previously had a sleep study?	☐ Yes / ☐ No
If yes, where and when was the study done?	
In your words describe your major concern (s) about your sleep, including when and how this began and what treatment you have received in the past.	

SLEEP SCHEDULE:

	Bedtime	**Wake Time**	**Average amount of sleep per night**
Weekdays:	_____am/pm	_____am/ pm	_____hours
Weekends:	_____am/pm	_____am/ pm	_____hours

Do you wake up feeling rested? ☐ YES / ☐ NO

Do you currently use CPAP treatment at night? ☐ YES/ ☐ NO

If so, what pressure: _____

Do you have rotating or night shift work? ☐ YES/ ☐ NO

How long does it take you to go to sleep? ____Hours _____Minutes

How many times a night do you wake up from sleep? ____

Do you fall back to sleep easily? ☐ YES/☐ NO

Do you nap? ☐ YES/☐ NO

If so, how often and how long? _____

SLEEP HISTORY:

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the certain situations, in contrast to just feeling tired?

This refers to your usual way of like in recent times. If you have not done some of these things recently, think about how they have affected you in the past.

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

0= no chance of dozing
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 you can:

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading	____	____	____	____
Watching TV	____	____	____	____
Sitting, inactive in a public (e.g. a theatre or a 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 the traffic	____	____	____	____

SLEEP HISTORY:

□YES □NO	Do you feel excessively tired during the day?	How often? _____
□YES □NO	Are you restless sleeper?	
□YES □NO	Have you been told you snore?	How often? _____
□YES □NO	Have you ever been told you quit breathing at night?	How often? _____
□YES □NO	Have you ever awakened gasping for breath?	How often? _____
□YES □NO	Do you have dry mouth in the morning?	How often? _____
□YES □NO	Do you have morning headaches?	How often? _____
□YES □NO	Has your weight fluctuated over the past 3 years?	How much? _____
□YES □NO	Do you have "tingly" legs/ feel as if you have to move them?	For how long? _____
□YES □NO	Do you kick your legs at night?	For how long? _____
□YES □NO	Do you grind your teeth in your sleep?	How often? _____
□YES □NO	Do you talk in your sleep?	For how long? _____
□YES □NO	Do you have difficulty staying awake when driving?	For how long? _____
□YES □NO	Have you ever had a motor vehicle accident due to sleepiness?	
□YES □NO	Have you ever had a hallucination or dream-like mental images when falling asleep?	
□YES □NO	Have you ever experienced weak knees during emotions like laughing, happiness, or anger?	How often? _____
□YES □NO	Have you ever experienced sagging of the jaw during emotions like laughing, happiness, or anger?	How often? _____

PAST MEDICAL HISTORY:

Please check all that apply:

☐ Hypertension	☐ Emphysema	☐ Diabetes	☐ Sinus Disease
☐ Heart Disease	☐ COPD	☐ Neuropathy	☐ Nasal surgery
☐ CHF	☐ Asthma	☐ Migraines	☐ Bed Wetting
☐ Cardiac Bypass	☐ Pulmonary Disease	☐ Ulcers	☐ Thyroid Disease
☐ Pace Maker	☐ Seizures	☐ High Cholesterol	☐ Acid Reflux

☐ Other: _____

CURRENT MEDICATIONS AND DOSING INSTRUCTIONS:

_____
_____
_____
_____

Drug Allergies: _____

Do you use supplemental oxygen? ☐ YES ☐ NO If yes, _____ liters/minute

Caffeine Use: ☐ Soda Pop ☐ Tea ☐ Coffee
How many cans/cups per day? _____

Tobacco Use: ☐ Never ☐ Currently Smoke ☐ Quit ☐ Currently Dip
How many packs per day? _____

Home: ☐ Married ☐ Widowed ☐ Divorced ☐ Single ☐ Legally Separated

Alcohol: ☐ Never ☐ Socially ☐ Daily ☐ Sober

Illicit Drugs: ☐ Never ☐ Occasionally ☐ Daily ☐ Quit

Work: ☐ Retired ☐ Disabled ☐ Student ☐ Employed ☐ Part-time

☐ Shift work ☐ Night shift

FAMILY HISTORY: *(Father, mother, brother, and or sister):*

	Person with disorder		*Person with disorder*
☐ Diabetes	_____	☐ Narcolepsy	_____
☐ Hypertension	_____	☐ Snoring	_____
☐ Stroke	_____	☐ Depression	_____
☐ Obesity	_____	☐ Daytime Fatigue	_____
☐ Sleep Apnea	_____	☐ Migraines	_____

Review of Systems:

Please circle or check all that apply

Constitutional Review: □Fever/ □Night Sweats/ □Unexplained weight loss/ □Unexplained weight gain

Ear, Nose, and Throat Review: □Hearing Loss/ □Tinnitus/ □Trouble Swallowing/ □Nasal Congestion

Pulmonary Review: □Coughing/ □Shortness of breath/ □Wheezing/ □Coughing up blood/ □Difficulty breathing lying flat

Musculoskeletal Review: □Muscle ache/ □Joint pain

Endocrine Review: □Excessive thirst/ □Unusually moist or dry skin/ □Heat intolerance/ □Cold intolerance

Psychosocial/Social Review: □Loss of appetite/ □Feeling depressed or down/ □Anxiety/ □Agitation/ □Increased stress

Cardiac Review: □Chest pain/ □Ankle Swelling/ □Heat Murmur

GI Review: □Black stools or bleeding from bowels/ □Nausea/ □Vomiting/ □Abdominal Pain

BU Review: □Frequent bladder infections/ □Painful urination/ □Frequent urination/ □Blood in urine

Skin Review: □Skin rash/ □Easy bruising

Neurological Review: □Trouble with balance/ □History of stroke/ □Seizure/ □Difficulty concentrating/ □Headaches/ □Migraines/ □History of Restless legs

Other Complaints not mentioned: _____

_____

_____ _____ _____

Patient Signature Print Name Date

_____ _____

Physician signature Date