Welcome,

Our office screens all new patients for potential air flow disorders prior to any dental treatment. We also screen all existing patients periodically throughout the year. Please complete this form and return it to the front desk staff.

Patient Name: First ________________________________ Last ______________________________ **Gender**: Male Female

Patient Health History: Please check all that apply

	Type 2 diabetes		History of stroke
	Heavy snoring		Difficulty concentrating
	High cholesterol		Heart disease
	Restless sleep		Morning headaches
	Daytime sleepiness		High blood pressure
	Periodically stop breathing during sleep		Headaches/migraines
	COPD		Clench or grind your teeth
	Experience pain (head, jaw, neck, shoulder(s), arm(s), low back)		Been in car accident over 8 mph or any trauma (sports, injury, fall) in the last year

Below are 8 questions regarding sleepiness. Please circle only one answer per question. **Answer these questions as if it is your day off, you've had no stimulants, including caffeine, and you have the opportunity to relax.**

How Likely Are You To Fall Asleep While...	Never	Slight	Moderate	High
1) Sitting and reading?	0	1	2	3
2) Watching TV?	0	1	2	3
3) Sitting inactive in a public place (meeting, theater, etc.)?	0	1	2	3
4) As a passenger in a car for an hour without a break?	0	1	2	3
5) Lying down to rest in the afternoon when circumstances permit?	0	1	2	3
6) Sitting and talking to someone?	0	1	2	3
7) Sitting quietly after lunch without alcohol?	0	1	2	3
8) In a car while stopped for a few minutes in traffic?	0	1	2	3

Score Summary: _______

Patient Information: Please fill out the sections below. Those with asterisks (*) are required.

*Date of birth ____ *Height ________________ *Weight ____________________

*Address ____ *City _________________________*State _______ *ZIP ____________

SSN # ____ E-mail address ____

Phone numbers: Home __________________________ Cell __________________________ *Best #________________________

Neck circumference (office can measure if you are unsure) ____

Patient Signature:

Signature (if under 18 years of age, guardian signature needed) Date

_______ I have read/reviewed and agree to the HIPAA information on the opposite side of this page. Please initial upon completion.

HOME SLEEP TEST PATIENT ACKNOWLEDGEMENT AND AGREEMENT CONSENT TO PERFORM HOME SLEEP TEST AND RELATED SERVICES

The recipient voluntarily requests the doctor hereafter known as "HEALTHCARE PROVIDER", its associates, technical assistants, Doctor Alliance Group (DAG), and other healthcare providers to diagnose your sleep disorder as your physician may deem necessary. The associated acknowledgement and agreement applies only to the provided home sleep testing services and no other type of medical service. If any further consultation or service is required, you need to seek that service independently. Your acknowledgement and agreement certifies that you understand that the following diagnostic procedures are planned for you, and do voluntarily consent to and authorize these procedures.

DIAGNOSTIC PROCEDURES

In order to measure the various characteristics of your sleep, you understand that an elastic band will be placed around your chest and abdomen to measure your breathing during sleep. An oxygen sensor will be taped to your finger to measure your blood oxygen levels and heart rate. A small cannula will be taped to the side of your face, under your nose to measure the air flow which passes through your nose and mouth.

FINANCIAL AGREEMENT

You agree that in return for the services provided to the patient, you will pay the account of the patient and/or, prior to the performance of the study, make financial arrangements satisfactory to HEALTHCARE PROVIDER for payment. If the account is sent to an attorney for collection, you agree to pay reasonable attorney's fees and collection expenses. The amount of the attorney's fees shall be established by the court and not by a jury in any court action. If any signer is entitled to benefits of any type whatsoever under any policy of insurance insuring patient, or any other party liable to patient, the benefits are hereby assigned to HEALTHCARE PROVIDER for application on patient's bill. However, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL. Acknowledgement and agreement certifies this form has been fully explained to me; I have read it or have had it read to me; and I understand its contents. Acknowledgement and agreement authorizes HEALTHCARE PROVIDER to obtain any needed sleep study records for the purpose of review, evaluation and treatment in connection with my home sleep test and consent to the use or disclosure of my identifiable health information for treatment, payment and healthcare operations.

PATIENT BILL OF RIGHTS & RESPONISIBILITIES

We believe that all patients receiving services should be informed of their rights. Therefore, you are entitled to:

1. Be fully informed in advance about service/care to be provided, including the disciplines that furnish service/care.
2. Participate in the development of the plan of service/care.
3. Informed consent and refusal of service/care or treatment after the consequences of refusing service/care or treatment are fully presented.
4. Be informed in advance of service/care being provided, of the charges, including payment for service/care expected from third parties and any charges for which the patient will be responsible.
5. Be treated with respect, consideration, and recognition of patient dignity and individuality.
6. Be able to identify staff members through proper identification.
7. Voice grievances/complaints regarding treatment or care, lack of respect of property or recommended changes in policy, staff, or service/care without restraint, interference, coercion, discrimination, or reprisal.
8. Have grievances/complaints regarding treatment or care that is furnished, or lack of respect of property investigated.
9. Choose a healthcare provider.
10. Confidentiality and privacy of all information contained in the patient record and of Protected Health Information.
11. Be advised on agency's policies and procedures regarding the disclosure of clinical records.
12. Receive appropriate service/care without discrimination in accordance with physician orders.
13. Be informed of any financial benefits when referred to an organization.
14. Be fully informed of one's responsibilities.
15. Be informed of provider service/care limitations.

PATIENT RESPONSIBILITIES

1. Patient agrees to request payment of authorized Medicare, Medicaid, or other private insurance benefits that are paid directly to HEALTHCARE PROVIDER for any services furnished by HEALTHCARE PROVIDER.
2. Patient agrees to accept all financial responsibility for service furnished by HEALTHCARE PROVIDER.
3. Patient understands HEALTHCARE PROVIDER retains the right to refuse delivery of service to any patient at any time.
4. Patient agrees that any legal fees resulting from a disagreement between the parties shall be borne by the unsuccessful party in any legal action taken.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information• is information about you, including demographic information, that my identify you and that relates to your past, present or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. Further, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, criminal activity, inmates, military activity, national security, and worker's compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is an explanation of your rights with respect to your PHI. You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that that is subject to law that prohibits access to PHI. You have the right to request a restriction of you PHI. This means you may ask us to not use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You have the right to request to receive confidential communications from us by alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us. This will be provided upon request, even if you have agreed to accept this notice alternatively. You may have the right to have our organization amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may also file a complaint with us directly.

We are required by law: to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any questions concerning or objections to this form, please contact us.

GRIEVANCE/COMPLAINT REPORTING

You may file a complaint without concern for reprisal or discrimination. To place a grievance you may call the HEALTHCARE PROVIDER. If your compliant is not resolved to your satisfaction within 5 working days, you may initiate a formal grievance, in writing and forward it to the Director of Clinical Operations of the company. You can expect a written response within 14 working days of receipt.

CONSENT OF SERVICES

I hereby give consent to HEALTHCARE PROVIDER, its contractors, physicians and employees to provide healthcare services to me and to administer physician orders for my benefit for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I further give consent and agree that my dentist will give a contracted health consulting company, DAG, my PHI in order to contact my Primary Care Physician (PCP) and set up a Home Sleep Test (HST). DAG will further track and deliver my results to the PCP, the dentist and a sleep lab physician, along with recommendations to the appropriate healthcare providers. I understand that there is a risk of substantial and serious harm involved in such healthcare services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty in the healthcare services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for some of the services they perform.

HOME SLEEP TESTING DEVICE AGREEMENT

The acknowledging patient hereby agrees to conduct the home sleep test (HST) he/she receives the device and has been instructed or provided with instructions on its use. He/she also agrees to return the device to HEALTHCARE PROVIDER before noon following the conclusion of the HST. He/she agrees to immediately take the test and return the equipment to HEALTHCARE PROVIDER. The patient understands that if he/she fails to return the device within 5 days from receipt, he/she may be responsible to pay a fee of $100 per day for each day after the test has been authorized. He/she also understands if he/she fails to return the device all together, he/she is responsible for the cost of the device which shall equal no more than $3,500.00.

PRIVACY PRACTICE

I hereby acknowledge that I have received or been offered a copy of HEALTHCARE PROVIDER'S Notice of Privacy Practice. The undersigned signs this document either as the Patient of Record or as the agent or representative of the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing.

DAG.
DOCTOR ALLIANCE GROUP

OFFICE USE ONLY SECTIONS

Patient Sent Home with Pulse Oximeter:	**YES**	**NO**
1. Patient sent home with pulse oximeter?		
2. Patient plans on moving forward in future?		
3. Patient has CPAP?		
4. Patient is CPAP compliant?		

20 Minute Appointment Scheduling	**YES**	**NO**
1. Appointment scheduled?		
2. Patient opted to move forward?		

20 Minute Appointment	**YES**	**NO**
1. Appointment completed?		
2. Medical insurance card uploaded, front and back?		

Schedule Appointment with Sleep Specialist

1. Patient referred for sleep exam consultation with Dr. ______________________ (a board certified sleep physician)
2. Date of appointment with sleep specialist: ____________________

Dentist Signature Print Dentist's Name Date