Absolute Sleep of The Carolinas
Achieving Longer Lives through Better Sleep

ABSOLUTE SLEEP OF THE CAROLINAS

NEW PATIENT FORM:

Patients Information:

First:	MI:	Last:	DOB:	SS#
Home Phone:	Cell Phone:	Email:		
Preferred Method of Contact:	Best time to contact: Morn/Noon/Night	Height:	Weight:	
Address:	City:	State:	Zip:	
Marital Status:	Emergency Contact:	Relationship:		
Phone:	Referred by:			

Employer Information:

Employer:	Phone:		
Address:	City:	State:	Zip:

Insurance Information:

Insurance:	Group Policy/TWCC #:	Group Name:	
Insurance ID #:	Plan Name:	Relationship to Insured:	
First:	MI:	Last:	DOB:
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Email:
Insured Employer:			

Secondary Insurance Information:

Insurance:	Group Policy/TWCC #:	Group Name:
Insurance ID #:	Plan Name:	Relationship to Insured:
If other than self, please provide the insured persons DOB:		

Medical Contacts:

Absolute Sleep of the Carolinas coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.	
Primary Care Physician:	Phone:
ENT:	Phone:
Sleep Doctor:	Phone:
Dentist:	Phone:
Other Doctor:	Phone:
Other Doctor:	Phone:

I CERTIFY THIS INFORMATION TO BE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

_____ Signature

_____ Date

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Medical History Update

Name: _____ Date: _____

Have you ever been given a CPAP device?	Y	N
If you have been given a CPAP device, do you use it every night?	Y	N
Are you comfortable with your CPAP device and satisfied with its use?	Y	N

If you answered *YES* to all three of these questions, you are done, and you may sign and date the bottom of the form. If you answered *NO* to any of these questions, please continue to Part 1 of the form.

PART 1: Epworth Sleepiness Scale

How likely are you to doze off while doing any of the follow activities? Please circle one of the numbers using the following scale: 0 = Never, 1 = Slight, 2 = Moderate, 3 = High.

Being a passenger in a motor vehicle for an hour or more…..	0	1	2	3
Sitting and talking to someone…..	0	1	2	3
Sitting and reading…..	0	1	2	3
Watching TV…..	0	1	2	3
Sitting inactive in a public place…..	0	1	2	3
Lying down to rest in the afternoon…..	0	1	2	3
Sitting quietly after lunch without alcohol…..	0	1	2	3
In a car, while stopped for a few minutes in traffic…..	0	1	2	3

Total: **Score of 8 or more = 1 diagnostic point.**

PART 2: Every *YES* = diagnostic point.

Have you ever been told you snore?	Y	N
Do you wake up choking or gasping?	Y	N
Have you had high blood pressure?	Y	N
Do you have diabetes?	Y	N
Have you ever experienced an irregular heart rhythm?	Y	N

Part 3: Every *YES* = 1 diagnostic point.

Does snoring cause any problems at home?	Y	N
Would you like to fix it? (If yes to above question)	Y	N

PART 4: (COMPLETED BY ASSISTANT OR HYGIENIST)

Neck Size: _____ **(Excessive Neck size (Female > 15, Male > 16.5) = 1 diagnostic point).**
Height: _____ Weight: _____ BMI: _____ **(BMI > 30 = 1 diagnostic point).**
Mallampati: _____ **(Class III or greater = 1 diagnostic point).**
Scalloped Tongue: _____ **(Scalloped tongue = 1 diagnostic point).**
_____ Schedule telemedicine visit.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: _____ **DOB:** _____

I request and authorize the release of healthcare information of the patient named above to:

Office: Absolute Sleep of the Carolinas

Address: 166 Furman Rd Suite A

City: Boone **State:** NC **Zip**: 28607

Phone: (828) 832-8081

Fax: (828) 264-9939

Contact: Dr. Steven Airey, DDS

- All health care information regarding said patient for the past year.
- All medical records with need for care of sleep apnea

I herby authorize and instruct _____to transfer copies of records to the address listed above.

_____ _____

Signature Date

This authorization expires ninety days after it is signed.

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ASSIGNEMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made either to me or on my behalf to the organization listed below for any equipment of services provided to me by that organization. I herby assign and convey directly to the below named health care provider (Absolute Sleep of the Carolinas), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the provider, regardless of its managed care network participation status.

I understand that I am financially responsible to the provider for any charges regardless of health care benefits. It is my responsibility to notify the provider of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the provider and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I herby authorize the provider to release all medical information necessary to process my claims. Further, I herby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the provider of it's attorneys in order to claim such medical benefits.

In addition, I also assign and/or convey to the provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by the assignment and designation of authorized representative to convey to the provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative Absolute Sleep of the Carolinas is given the right by me to (1) obtain information regarding the claim to the same extent as me. (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan or plan administrator. The provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at providers expense

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Provider: Absolute Sleep of the Carolinas, Dr. Steven Airey, 166 Furman Rd. Ste A Boone, NC 28607

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT

_____	_____	_____
Signature	Printed	Date
_____	_____	_____
Witness Signature	Printed	Date

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Absolute Sleep of the Carolinas

166 Furman Rd Ste. A
Boone, NC 28607

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

Purpose: Absolute Sleep of the Carolinas is committed to protecting Health information about you, ASC and its employees, non-employees, and all of their affiliated entities follow the privacy practices described in this notice. ASC maintains your health information in records that are kept in a confidential manner, as required by law. ASC must use and disclose or share your health information as necessary for treatment, payment and health care operations to provide you with quality health care.

Use and release of your health information for treatment, payment and health care operations: ASC has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your case. For example, your health care provider may share information about your condition with sleep physicians or other consultants to make a diagnosis. ASC may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, ASC may use and disclose your health information to improve the quality of care, and for education and training purposes of ASC employees or affiliated entities.

How will ASC use and disclose my health information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:

Note: You will have the opportunity to refuse some of these communications about your health information, indicated by (*).

- Family members or close friends involved in your care or payment for treatment. *
- Dental Sleep Solutions (DS3). DS3 is a secure computer system for health care providers to share your health information to support treatment, healthcare operations and continuity of care. Your record in the DS3 includes prescriptions, lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are your full name, date or birth and social security number. All information contained in the DS3 is kept private and used in accordance with applicable state and federal laws and regulations.
- Appointment reminders
- To contact you regarding treatment alternatives.

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- **Right to request amendment.** If you believe that the health information we have for you is incorrect or incomplete, you may request an amendment on the form provided by ASC.
  ASC is not required to accept the amendment.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your health information that been made to persons or entities during the past six years prior to the request. This does not include disclosure for health care treatment, payment and operations, disclosure based on patient authorization or as required by law. There may be additional charges for any additional request after the first one has been completed.
- **Right to restrict certain disclosure to a Health Plan.** You may request a restriction of certain disclosures of your protected health information to a health plan if you have paid out of pocket in full for the health care item or service.
- **Right to a copy of this Notice.** You may request a paper copy of the Notice at any time, even if you have been provided with an electronic copy.

Requirements regarding this notice. ASC is required by law to provide you with this notice. We will comply with this notice for as long as it is in effect. ASC may change this notice at any time. These changes will be effective for health information we about you, as well as any information we receive in the future.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, DC 20201

We will not penalize or retaliate against you in any way for making a complaint to ASC or to the Department of Health and human Services. We will notify you in the unlikely event of a breach of your unsecured protected health information.

Contact ASC at (828) 832-8081 if:

- You have any questions about this notice
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations
- You wish to obtain a form to exercise your individual rights.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence.

- Health oversight activities, such as audits, inspections, investigations and licensure.
- Law enforcement, as required by federal, state or local law
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other lawful request.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- To carry out health care treatment, payment and operational functions through business associates, such as to install a new computer system.

Your authorization is required for other disclosures. Your authorization will be required for most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes and disclosures that constitute a sale of protected health information. Except as described above, we will not use or disclose your medical information, unless you allow ASC in writing to do so. For example, we will not use your photographs for presentations outside ASC without your written consent. You may withdraw or revoke your consent, which will be effective only after the date or you written withdrawal notice.

You have rights regarding your health information. You have the following rights regarding your medical information, if requested on the forms provided by ASC:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for health care treatment, payment or operations. We are not required to comply with your request. For example, you may ask us not to disclose that you have had a procedure. We will release the information if necessary, for emergency treatment. We will notify you in writing whether we honor your request or not.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to inspect and copy.** You have to right to review and obtain a copy of your medical or health records. We may charge a fee for copying, mailing and required supplies. Under limited circumstances, your request may be denied. You may request review of the denial by another licensed health care professional chosen by ASC. ASC will comply with the outcome of the review.