SLEEP LINK - SOUTHWEST
Patient Questionnaire

EPSWORTH SLEEPINESS SCALE

In contrast to feeling tired, are you likely to dose off or fall asleep in the following situations:

Please choose the most appropriate number for each situation:

0=Never	1=Slight Chance	2=Moderate Chance	3=High Chance

Situation	Score
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. Theater)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car while stopped briefly in traffic	_____
Totals: add the list above.	_____

If 10 or greater you need to see your Doctor immediately and give him the survey results, and he will determine further follow-up and PSG (Sleep Study) Testing.

If 5-10 score, complete the pre-testing questionnaire and if you answered several questions always or most of the time- take to doctor for his evaluation. (pre-testing questionnaire is located under forms section)

Frequently	Most of the time	Always

Please circle the appropriate responses:

I use oxygen at night.	Yes/No	I have high blood pressure.	Yes/No
I currently use CPAP at night.	Yes/No	I have an irregular heart beat.	Yes/No
I use sleep medications.	Yes/No	I have had a heart attack.	Yes/No
I currently smoke.	Yes/No	I have diabetes.	Yes/No
I have smoked in the past.	Yes/No	I have lung disease or asthma.	Yes/No
I drink alcohol prior to bedtime.	Yes/No	I have had a stroke or TIA.	Yes/No

I have had a tonsillectomy.	**Yes/No**	**I have chest pain at night.**	**Yes/No**
I have had lung surgery.	**Yes/No**	**I have fibromyalgia.**	**Yes/No**
I currently use a mouth guard.	**Yes/No**	**I have seizures.**	**Yes/No**
I have had an abnormal chest X-Ray.	**Yes/No**	**I have been exposed to excessive amounts of dust.**	**Yes/No**
I have been exposed to fumes or chemicals at work.	**Yes/No**		

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Sleep LINK - SOUTHWEST
1902 Ave. G NW, Suite I-1
Childress, TX 79201
(940) 937-0400
(940) 937-0401 Fax

INSURANCE AUTHORIZATION
&

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____

Insurance ID: ____

I request that payment of authorized insurance benefits be made to Sleep Link on my behalf for any services furnished to me by the lab.

I authorize any holder of medical information about me to release to the health care financing department, and it's agents, any information necessary to determine the benefits for related services.

I authorize Sleep Link to obtain my personal medical/health records for the sole purpose of gaining information requested by my insurance carrier to file services rendered.

If for any reason my insurance denies payment for services rendered, I agree to be personally and fully responsible for payment.

Lifetime Signature: _______________________________

This consent is for *Sleep Link*.

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices.

____ ________________________

Signature of Patient or Legal Representative Witness

__________________ ________________________

Date Effective Date

Authorized persons: ____

The purpose of this consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of this provider or organization.

Your consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this 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/es and other health information to my bill(s).

Consent Form- Continued

- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by *Sleep Link*
- I have the right to review the Notice of Information Practices prior to signing this consent;
- *Sleep Link* can change its Notice of Information Practices but must notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that *Sleep Link* is not required to agree to those restrictions;
- Any restrictions to which *Sleep Link* agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that *Sleep Link* can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of *Sleep Link* please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction.

I request the following restrictions to the use or disclosure of my health information:

____

For provider use only:

Restriction is

- ☐ Accepted
- ☐ Denied

Reason denied:

Patient is notified?

- ☐ Yes
- ☐ No