Sleep Services of Maryland

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■ Rockville
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19735 Germantown Rd, Ste. 305, Germantown, MD 20874

PATIENT INFORMATION

Today's Date: _____

First Name:_____ **Middle Name:**_____

Last Name: _____ **Date of Birth:** _____

Sex: _____ **Age**: _____ **Email**: _____

Mobile Phone: _____ **Home Phone:** _____

Address: _____

City: _____ **Zip Code:** _____

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Emergency Phone:**_____

Referring Physician & Phone #: _____

Primary Care Physician and Phone #: _____

Preferred Pharmacy name & Phone #: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed Spouse Name:_____

Race: □ White □ Hispanic □ Black/African American □ Asian □ Other

□ American Indian/Alaskan Native □Refused to Report

Ethnicity: □ Hispanic □ Non Hispanic □ Refused to Report

Language: □ English □ Spanish □ Russian □ Indian (Hindi/Tamil) □ French □ Other

Insurance Information

Primary Insurance name: _____ ID# _____

Secondary Insurance: _____ ID# _____

Tertiary Insurance: _____ID# _____

□ Self Pay

FINANCIAL POLICY

I hereby authorize **SLEEP SERVICES OF MARYLAND** to release any information requested with respect to insurance claims and bills as the provider of the service rendered. I hereby authorize payment of insurance benefits directly to SLEEP SERVICES OF MARYLAND. In instances where I receive payment for services from my own insurance carrier, I agree to endorse form of payment made out to SLEEP SERVICES OF MARYLAND.

If your health insurance is covered with Sleep Medicine benefits, we will be happy to bill your insurance. With the provided insurance information, we will verify coverage as a courtesy. However, please note that acceptance of your insurance does not exempt your financial responsibilities and you will be held accountable for any unpaid balances by your plan. **Although we are contracted with most insurance carriers, our services may not be covered by a particular insurance plan. We highly recommend you contact your insurance carrier to verify questions regarding coverage for Sleep Medicine.** Moreover, if you have more than one insurance policy, please do not assume you will not owe anything.

I understand that I am financially responsible for the charges not covered by insurance.

PATIENT FINANCIAL REPONSABILITY

As a courtesy, SLEEP SERVICES OF MARYLAND verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of SLEEP SERVICES OF MARYLAND that payment is due at the time of service. You are accountable for insurance fees (whether it be the copay, deductible, or coinsurance) at the time of your visit.

Please notify our staff if you are part of a program (i.e., Care Program) and/or have a Health Savings Account (HSA) or other benefit program that exempts you from this policy. At the conclusion of your visit(s), you may be billed for any outstanding balances.

If there is a credit on your account, a refund will be issued promptly.

Referrals: Additionally, I understand that if my insurance carrier requires a written referral from my PRIMARY CARE PHYSICIAN, THE STATE OR OTHER ORGANIZATION, I am responsible for obtaining the referral prior to the service.

CANCELLATION & NO SHOW POLICY:

Doctor's Appointments: Late arrivals/Missed appointments/Less Than 24 Hour Notice Once an appointment has been made, please respect the time that has been reserved in our office for you. We make every attempt to give our patient a courtesy call reminding you of your appointment time, but it is your responsibility to make sure you have this information, so you do not miss your appointment. Please note that if you are late for your appointment, you may be asked to reschedule. Please be considerate and call our office as early as possible if you are unable to keep your scheduled appointment. **Missed appointments as well as cancellations less than 24 hours will incur a charge of $50**. This amount shall be paid by your and will not be billed to your insurance company. A bill will be mailed to you with this balance.

Sleep Study Procedures: Due to a large block of time needed for procedures and staffing requirements, cancellations need to be made 24 hours in advance on weeknights and 48 hours in advance on weekends. **Missed appointments as well as failure to cancel within allotted time will result in a $150** fee not covered by your insurance company.

Patient (guardian) Signature: _____ Date: _____

PATIENT RESPONSIBILITIES AND OFFICE POLICIES

Appointments: Upon registration, you will receive courteous reminders via email, text or voice message. Please inform the staff if you have a preference on confirmations.
Medicare Patients: I authorize Sleep Services of Maryland to release medical information about me/patient to the Social Security Administration or its intermediaries for my Medicare claims. I hereby the benefits payable for service to Sleep Services of Maryland.
Prescription History retrieval: I authorize Sleep Services of Maryland to obtain prescription medication history from my health insurance company
Consent to call/text/email: I consent to receive, Phone Calls □ Text Messages □ Emails □
Insurance Policy: It is the patient's responsibility to know your insurance policy and understand your benefits. It is the patient's responsibility to understand your policy benefits and know what is covered and not covered. It is patient's responsibility to inform all insurance changes at the time of service.
Insurance: Patient must present with appropriate insurance information at the time of service, or the patient will be considered self-pay for the full cost of the visit. If any of the above information is missing, the patient will be rescheduled to a later appointment or accept financial responsibility for the visit.
Referrals: I understand that if my insurance carrier requires a written referral from my Primary Care Physician, the state or other organization, I am responsible for obtaining the referral prior to the service.
Copayments: Co-payments must be paid prior to each visit. This is required in terms of your contact with your insurance company. I also understand that if I fail to maintain consistent payments, my account will be referred to a collection agency and/or attorney, and I agree to pay all related collection fees. Forms of copayment accepted are cash, VISA, MasterCard, Discover, American Express or check. Any returned check will be subject to a $50.00 charge. If a payment is not received in a timely manner the account will be forwarded to collection services.
Refills: Prescription refills require 48 hours to be processed. Please call your pharmacy and request that they fax us a refill request or log into the patient portal to request a refill.
Form Fee: There is an additional fee of $25 or more depending on the size for the completion of forms. Forms may require 24-72 hours to complete.
Medical Records: We require a written request to provide medical records to you or your designated healthcare provider/entity. Printing medical records physically is subject to a charge of .75 cents per page or higher consistent with standards set by the Maryland Board of Physicians. Please allow up to 7 business days to have the printed medical records ready for you. We will be happy to fax your medical records to your preferred destination or provide you an encrypted digital copy of your health records free of cost.
Control Substance Prescription Policy: SLEEP SERVICES OF MARYLAND reserves the right to perform a random drug screening test as a condition to prescribing controlled substances. Refusal to random drug screening may lead to denial of prescription for controlled substances. Prescriptions for controlled substances are issued only during appointments and Controlled substances will NOT be refilled early due to misuse.
Credit card on file: We have implemented a credit card on file policy which applies to all Insurances that have a deductible plan. You will be asked for a credit card information at the time you check in. If you do not have a credit card available at the time of your check-in Sleep services of Maryland reserve the right to request an open credit of $250 prior to each visit. This credit will be applied to your balance once an EOB is received from your insurance company.

I have reviewed my patient's rights and responsibilities. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (guardian) Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA NOTICE OF PRIVACY PRACTICESAs required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 health care 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 may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information 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 health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information 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 protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information 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. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information 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 Workers’ 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: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. 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 protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. 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 rebuttalYou have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Avenue, S.W Washington, D.C. 20201 calling 1-877-696-6775 or on-line at: www.hhs.gov/ocr/privacy/hipaa/complaints/ if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy Officer of your complaint at 15200 Shady Grove Rd, Suite 401 Rockville, MD 20850, 240-912-4683 We will not retaliate against you for filing a complaint.

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 protected health information, if you have any questions concerning or objections to this form, please ask to speak with our HIPAA Privacy Officer. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Patient/Guardian Signature _____ Date _____

Sleep Services of Maryland

Epworth Sleepiness Scale

Patient Name: _____ **DOB:** _____ **Date:**_____

How sleepy are you?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- **0** = No chance of dozing
- **1** = Slight chance of dozing
- **2** = Moderate chance of dozing
- **3** = High chance of dozing

Select the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of dozing			
	0	1	2	3
Sitting and reading	○	○	○	○
Watching TV	○	○	○	○
Sitting inactive in a public place (e.g., a theater 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 traffic	○	○	○	○

MEDICAL HISTORY & MEDICATION LIST

Have any of your relatives ever had chronic sleep related problems? ( )Yes ( )No

If yes, describe the problem and this person's relationship to you: _____

_____

_____

_____

How much alcohol do you typically drink per week? _____ drinks

Do you consider yourself a **light, normal or heavy sleeper**? Circle one

Medical History (past surgeries, injuries, significant family conditions) :_____

_____

_____

_____

Allergies: _____

_____

_____

List all currently used drugs or medications (including illegal, over the counter & prescribed drugs/medications):

Drug/Medication	**Dosage & reason for taking the medication**

Patient (guardian) Signature: _____ Date: _____

Sleep Services of Maryland

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____

I request and authorize **Sleep Services of Maryland** to release my healthcare information to:

Practice/Physician's name:. _____

Phone:_____ Fax: _____

Address: _____

City: _____ State: _____ Zip code: _____

I authorize the custodian of records at Sleep Services of Maryland to release and/or disclose my sleep study results and any other health information necessary for my medical care, including, but not limited to, previous medical records, laboratory and pathology reports, imaging studies (e.g., X-rays), billing records, medical summaries, abstracts, and pharmacy/prescription records.

Note: I understand that these records may include sensitive health information, including information related to HIV/AIDS, behavioral or mental health, cancer diagnosis or treatment, drug and/or alcohol use or treatment, and sexually transmitted infections (STIs). By signing this authorization, I specifically authorize the release and disclosure of such information to the extent permitted by applicable federal and state law.

Please send records listed to (Include Name and Fax number):

□ PCP: _____

□ Referring Physician: _____

□ Health Care Team: _____

□ Others specified: _____

□ Check this box and do not sign below if you decline to authorize Sleep Services of Maryland to disclose or release your health information.

Patient (guardian) Signature: _____ Date: _____

This authorization expires one year after it is signed and may be revoked by the patient at any time.