8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member™
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

NEW PATIENT FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: _____

Address: _____ City & State: _____ Zip : _____

Home phone #: _____ Cell Phone#: _____ Social Security #: _____

Email: _____ Phone #: _____

Drivers Licence: _____

Pharmacy: _____ State: _____

Employer: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

ASSIGNMENT OF BENEFITS I hearby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insuran ce and any other health plan to 8 Hour Sleep Clinic.This agreement will remain in effect until revoked by me in writing. A photoco py of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by ins urance and I hearby authorize said assignee to release all information necessary to secure payment.

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signed : _____ Date : _____

8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are commited to your treatment being successful.
Please uderstand that payment of your bills is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read, agree to, and sign prior to any treatment and the providers of 8 Hour Sleep Clinic render only services that, in their professional judgment, are needed to provide quality medical care for you.

PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECK, VISA, OR MASTERCARD

REGARDING INSURANCE

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your med i-cal expenses with us.

*The patient is responsible for payment of any deductible and co-payments prior to or at the timeservices are rendered.

*Any portion of a billed amount that is labeled "not allowed" or "not covered" will be the patient's responsibility.

*Our office NEVER guarantees that your insurance will pay, or that they will pay what they quoted our benefits team. We will make every attempt at the beginning of your health care to receive verification of your policy benefits. However, if for some reason your insurance claim is denied, you are responsible for the amount due on your account.

*Your insurance is a contract between you and the insurance company. We are not party to that contract. While we have an agreement with the Plan to provide services, any questions regarding coverage must be resolved by you with your insurance company.

NSF CHECKS

All returned checks will assess a $30.00 fee. All returned checks not paid in 15 days will be filed with the proper authorities.
Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours notice for office appointments and Sleep Studies you will be billed:

Thank you for understanding our financial policy and the necessity of explaining this in writing to our patients. Please let us know if you have any questions or concerns:

$50 for clinic appointments
$100 for Sleep Study appointments

I have read, understand, and agree to the provisions of this financial policy.

Signature of patient or responsible party

Date

8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

8 Hour Sleep Clinic

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 inormation.
This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information that may identify you and it relates to your past, pres - ent or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your protected health information (PHI) may be used and disclosed by your physician, 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 physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with any related health services. This includes the coordination or management of your health care with a third party. 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 PHI will be used, as needed, to obtain payment for your health care services; For example, obtaining approval for an overnight sleep study may require that your relevant protected health information be disclosed to obtain approval for an overnight sleep study .

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing or conducting or arrangig for other business activities.

In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the physician waiting room when your room is ready. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, abuse or neglect, FDA requirements, legal proceedings, law enforcements, coroners, criminal activities, military activities and national security, and worker's compensation. 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 require - ments of section 164.500 other permitted and required uses and disclosures will be made only with your consent, authoriza - tion or opportunity to object unless required by law.

You may revoke the authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative	Name of Personal Representative
Date	Description of Personal Representative

8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member™
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

PATIENT INFORMATION

Name: _____ DOB : ____/____/____/

Chief Complaint: _____

SLEEP HISTORY

Wake Up: _____ ☐AM ☐PM Bedtime: _____ ☐AM ☐PM

Number of awakenings during the night: _____ Trips to the bathroom during the night: _____

Do you take any sleep aids to help you sleep? : ☐Yes ☐No If yes, what kind? : _____

Do you have a history of any of the following (Check if " YES" to any of the following) :

- ☐ Difficulty falling asleep at night
- ☐ Snoring
- ☐ Witnessed apneas
- ☐ Gasping/choking during sleep
- ☐ Sweating/perspiring in sleep
- ☐ Drooling in sleep
- ☐ Dry mouth upon awakening
- ☐ Teeth grinding/clenching
- ☐ Excessive movements in sleep
- ☐ Nightmares/bad dreams
- ☐ Sleep walking
- ☐ Sleep talking
- ☐ Acting out dreams
- ☐ Morning headaches
- ☐ Difficulty staying asleep
- ☐ Heart palpitations
- ☐ GERD/reflux/heartburn
- ☐ Excessive daytime sleepiness
- ☐ Tired/fatigued during the daytime
- ☐ Nasal allergies/nasal congestion
- ☐ Asthma
- ☐ TMJ pain/jaw discomfort
- ☐ Bedwetting
- ☐ Erectile dysfunction
- ☐ Decreased libido
- ☐ Hypertension
- ☐ Depressed mood/irritability
- ☐ Anxiety/stressed out
- ☐ Difficulty with concentration
- ☐ Memory problems
- ☐ Cold hands/feet
- ☐ Chest pain/chest discomfort
- ☐ Shortness of breath during the day

SURGICAL HISTORY

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICAL HISTORY

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you ever had your tonsils and/or adenoids surgically removed? ☐Yes ☐No

MEDICATIONS (including prescription and over-the-counter)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGY HISTORY (to any medications or substances)

☐No Know ☐Yes to : 1. _____ 2. _____

8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member™
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

SOCIAL HISTORY

Caffeine: _____ # of cups of coffee per day. _____ # of cups or glasses of tea per day.
_____ # of cans or glasses of soda per day. _____ # of servings of chocolate per week.

Alcohol : ☐ Yes ☐ No _____ # amount per day.
Tobacco: ☐ Yes ☐ No _____ # of packs per day. _____ # of days per week.
Recreational Drugs (such as marijuana or cocaine): ☐ Yes ☐ No
If yes, which ones? : _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation? : _____

Children : ☐ Yes ☐ No How many? _____ Pets : ☐ Yes ☐ No How many? _____

Do you have any children or pets that sleep in your bedroom? : ☐ Yes ☐ No

FAMILY HISTORY

Do you have a family history of any of the following medical illnesses? (Check if " yes" to all that apply)::

- ☐ High blood pressure/HTN
- ☐ Heart disease
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Overweight/obesity
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Chronic insomnia
- ☐ Restless legs syndrome
- ☐ Multiple sclerosis
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep walking

8 Hour Sleep Clinic

7430 N.Mesa St. El Paso, Texas 79912
AASM ACCREDITED Facility Member
2000 Lomaland Dr. El Paso, Texas 79935
(915) 875-1801 (915) 875-1516
administration@8hoursleepclinics.com

POLICY REGARDING PATIENT FORMS & ENDORSEMENTS

PURPOSE

In an effort to alleviate the overhead burden and volume of the increasing amounts of patient requested healthcare information that enters our office, Palouse Medical has been forced to charge for the completion of forms which are not directly associated with the medical care provided to our patients.

POLICY

This policy pertains to external documents that require a healthcare provider to authenticate patient health, provide their signature to verify information found within the document, or to approve/provide medical clearance for an external organization. Effective APRIL 1 1ST, 2019, 8 Hour sleep clinic will categorize all external documents that require the attention of a healthcare provider as either a "FORM" or an "ENDORSEMENT" and will charge for the completion of forms. Forms will be assessed a fee that will be collected before the provider completes the document. This fee will be charged at a rate of $25 for up to 2 pages and an additional $15 for each additional page. Forms will be filled out within 5 business days of payment.

FORMS can be defined as an externally produced document that:

- Requires MORE than 5 minutes of provider time
- Requires chart review
- Benefits the patient financially

Endorsements will not be assessed a fee as long as the patient has had an appointment within the last 2 weeks pertaining to the topic of the endorsement and has had a physical within the last 12 months. If a chart has to be reviewed or an appointment is needed, the patient will be notified before the document can be completed.

ENDORSEMENTS can be defined as an externally produced document that:

- ONLY require a provider's signature
- Do NOT require chart review
- Stem from a recent physician order or provides clarification discussed during a rece

EXAMPLES

FMLA Paperwork
Life Insurance
Work Restriction Documentation (Non-L&I)
Academic Medical Withdrawal Letters/Documentation
Long Term Care Benefits
Child Care/Day Care Forms
Flex Spending Letters Of Medical Necessity
Sperm Donation/Egg Harvesting/Surrogacy Paperwork
Adoption/Foster Care
Justification Letters For Personal Reimbursement
Participation Social Service Programs
Subsidized Housing Applications
Disability Documents

- Applying/Renewing Benefits
- Parking Permits

ENDORSEMENTS EXAMPLES

Medica lPermissions/Clearance for participation in…

- Physical Fitness Classes
- Extreme Sports
- Advanced Studies
- Acceptance In Educational Institutions
- Scout Camp
- Travel
- Research Experiments/Studies
- Return To Work/School Forms

Medication/DME Permission To...

- Carry on person or in prohibited areas
- Have on airplane
- Have in public schools (for minors)

All forms and endorsements MUST be submitted with the patient portion of the document fully completed.
8 Hour sleep clinic reserves the right to request an appointment in lieu or in addition to completing an external document.