Sleep Centers of Arkansas
Searcy

Dear Guest,

Melissa and I would like to take this opportunity to welcome you to our lab. We have spent many hours preparing our lab to be as restful and comfortable as your own home. We realize that you are here for testing and part of that testing involves placing monitoring cables on your head and other parts of your body which may make it difficult to be comfortable. We can only hope that despite this fact the environment will be so peaceful that you will be able still get a restful night sleep. Your bedroom is equipped with select comfort beds which will allow you to make your bed as firm or as soft as you desire.

In the morning when you wake you may help yourself to coffee, juices and some continental type breakfast items. If we can do anything to make your stay more comfortable, please do not hesitate to ask.

Sincerely,

Harold L. Davis RRT

Harold L. Davis RRT

Owner

P.O. BOX 1258 • SEARCY, AR • 72145
PHONE: 501-268-6700 • FAX: 501-268-6715

Sleep Centers of AR-Searcy

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any 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 and evaluation information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and I my request a copy of any revised notice by contacting Sleep Centers of AR-Searcy office. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

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

_____

_____

_____

Signature Obtained on Acknowledgement of Receipt Form

_____ _____

Signature of Patient or Legal Representative Witness

_____ June 30, 2006

Date Notice Effective Date or Version

Sleep Centers of AR-Searcy Use Only

Restriction:

- Accepted
- Denied

_____ _____ _____

Signature Title Date

Patient Consent and Release Form

I hereby give permission for a Polysomnogram (Sleep Study) to be performed. I understand that from the time of arrival until departure, audio and video will be recorded for the safety of all parties involved during the procedure.

The recordings will be used for the sole purpose of medical diagnosis and/or as a teaching aide only under the direction of my referring and/or interpreting physician.

In the event of an emergency, I am aware that I will need to be transported by ambulance to the nearest emergency room for further evaluation and treatment.

I also give consent to Sleep Centers of Arkansas to release and/ or obtain information concerning my past medical history. I also give my permission for my insurance company and/or durable medical equipment company to obtain records for the sole purpose of filing insurance claims.

Signature Obtained on Acknowledgement of Receipt Form

Patient's Signature Date

Witness Signature Date

Take Home Information

What to expect after your sleep study:

Once complete your study is prepared for the doctor to read. The raw data is reviewed and you may receive preliminary results by phone within the first few days following your study. This is only done if you are confirmed to have obstructive sleep apnea and need to return for a second night for the treatment portion. Any and all information received at this point may be slightly different than when you receive it from the doctor. However, the end result will be the same; you will need to be scheduled for a CPAP titration. The purpose of the preliminary results is to provide a rapid treatment option to you. **The final results will be given to you by the board certified sleep doctor within 10-14 business days of your study.**

The CPAP titration consists of the same procedure as the diagnostic study with the addition of the CPAP placement. You will have the opportunity to select a mask that appeals to you, keep in mind the mask may be changed during the night if it is not working properly for you. The purpose of the CPAP titration is to determine the amount of pressure that is needed to maintain an open airway and observe how your body responds to the changes.

If you are observed to have severe obstructive sleep apnea or meet certain criteria you may be placed on the CPAP the first night. This process completes both nights in one night and is called a Split Night Study.

Once the titration is complete an order for the CPAP and equipment is sent to a Durable Medical Equipment company (DME). They will contact you to set you up with your CPAP. We ask that if you do not hear from a DME within one week after your CPAP titration that you contact our office. If you have questions in regards to pricing of the equipment you will need to direct them to your DME. If you have difficulties with your mask after you are set up please call your DME for assistance. You are allowed to change masks within a certain time period. Some DME companies give up to 30 days for mask returns.

You will also be contacted by Sleep Specialist for a follow up appointment for 6-8 weeks after your titration study, if you do not already have one. It is very important that you keep the follow up appointment to better ensure our success in treating your diagnosis properly and also most insurance companies require it.

Please keep in mind that there is always the possibility of extenuating circumstances that may cause your experience to deviate from the normal procedure.

As always we strive to make your experience with us a pleasant one. Please feel free to contact our office with any questions, concerns or comments. Our office number is **501-268-6700.**

Your technician for the night is _____

Sleep Centers of Arkansas - Searcy

Patient/Client Bill of Rights

As an individual receiving Sleep Diagnostic services, let it be known and understood that you have the following rights:

1. To select where you want to have Sleep Diagnostics performed.
2. To be provided with legitimate identification by any person or persons who provides services for you.
3. To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, race, sex, religion, ethnic origin, sexual preference or physical/mental handicap.
4. To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing the company who provides treatment or services for you and be free from neglect or abuse, be it physical or mental.
5. To assist in the development and planning of your diagnostic and treatment so that it is designed to satisfy, as best as possible to your current needs.
6. To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service , or the termination of service.
7. **To express concerns or grievances or recommend changes without fear of discrimination or reprisal you may contact the owners Harold or Melissa Davis by calling (501) 268-6700 or (877) 441-9691**. The Medicare hotline number is 1-800-213-5452.
8. To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments and risks of treatment.
9. To receive diagnostic services within the scope services as perscribed by your physician, promptly and professionally, while being fully informed as to company policies, procedures and charges.
10. To refuse treatment and services within the boundaries set by law, and to receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
11. To request and receive the opportunity to examine or review your medical records

Sleep Centers of Arkansas-Searcy LLC
306 East Market St
Searcy, AR 72143
501-268-6700

Written Financial Policy

Thank you for choosing Sleep Centers of Arkansas-Searcy. Our primary mission is to deliver the best and most comprehensive sleep services available in this area. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You may choose from:

- Cash, check, Visa, MasterCard or Discover Credit Cards
- NO INTEREST[1] Payment Plans[2] from Care Credit (Application available on-site or online at www.carecredit.com)
    - Allows you to pay overtime with NO INTEREST[1]
    - Convenient, low monthly payment plans[2] also available
    - No annual fees or pre-payment penalties

Sleep Centers of Arkansas-Searcy will send you a bill after all your insurances has paid. If you know that you have a high deductible, you may choose to pay for part or all of your service. If you have questions about your portion or the amount billed for this service feel free to contact our office at 501-268-6700.

If you have any questions, please do not hesitate to ask. We are here to help you get the best option for your sleep related issues.

____ Signature Obtained on Acknowledgement of Receipt Form

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1] If paid within the promotional period. Otherwise, interest assessed from service transaction. Minimum monthly payment required.

[2] Subject to credit approval.

By my signature below I acknowledge that I have received the below forms /policies and have had an opportunity to review these documents with Sleep Centers of Arkansas Staff.

- Welcome Letter
- HIPAA Privacy Practice Standards and given the opportunity to restrict access of records per policy.
- Consent/Release Form and do give consent for my study to be Video/ Audio recorded as well as consent for the disclosure of pertinent Patient Health Information (PHI) in order to obtain treatment for my condition.
- Take Home Information- What to expect after my test
- Patient/Client Bill of Rights
- Written Financial Policy
- Assignment of Benefits as stated below

I hereby authorize Sleep Centers of AR- Searcy to release to my insurance any information including the diagnosis and records of any treatment or examination rendered to me during the period of such medical or surgical care. I also request my insurance company to pay directly to Sleep Centers of AR- Searcy the amount due me in my pending claim for insurance benefits. I agree to be responsible for payment of my account, and agree to pay collection agency fees up to 50% of my balance, should my account be placed with a collection agency.

Signature:_____ Date:_____

Staff Signature:_____ Date:_____

If signed by other than the patient please state the relationship to the patient why the patient could not sign._____

_____

PRE-SLEEP QUESTIONNAIRE

Name:_____ Date:_____

1. Briefly describe last night's sleep._____
   _____
2. Did you take a nap today? YES NO If so, for how long?_____
3. Did you feel sleepy today? YES NO
   Describe:_____
   _____
4. Have you consumed any caffeine or alcohol today? YES NO If so, list the type and amount consumed:_____
5. Did anything out of the ordinary happen today? YES NO If so, please describe:_____
6. How tired or sleepy do you feel right now? Not at all Slightly Very
7. How alert do you feel right now? Not at all Slightly Very
8. Are you in pain right now? YES NO Where?_____

**********_Stop Here_**********

POST-SLEEP QUESTIONNAIRE

1. How long did it take you to fall asleep last night?_____
2. Compared to at home, was it? Longer Shorter Same
3. Did you have difficulty falling asleep? YES NO Why?_____
   _____
4. How many times do you think that you awoke last night? _____
5. How many hours do you think do you think you slept last night?_____
6. Compared to usual, was it? Longer Shorter Same
7. Do you remember dreaming last night? YES NO How many times?_____
8. How do you feel upon awakening? Rested Not Rested Same
9. How tired or sleepy do you feel right now? Not at all Slightly Very
10. Hot alert do you feel right now? Not at all Slightly Very
11. Are you in pain right now? YES NO If so, where? _____

Comments:_____
_____
_____
_____
_____
_____