DALLAS SLEEP
The Dallas Center For Sleep Disorders
Adults & Pediatrics

Raj Kakar, M.D., M.P.H., D.ABSM, FACP
Medical Director

PATIENT INFORMATION

Patient Name: _____ Pt Sex: _____ Birthday_____

Address: _____ Apt #: _____ Marital Status: _____

City & State: _____ Zip:_____

Home Phone # ( ) - _____ Cell Phone # ( ) - _____
Work Phone # ( ) - _____ Ext: _____
Pharmacy Name: _____
Main Cross Streets: _____
Pharmacy Phone # ( ) - _____ Fax # ( ) - _____

Social Security #: _____

Drivers License #: _____ State: _____

Employer: _____
Employer Address: _____
Emergency Contact: _____ Phone # _____
Relationship to Patient: _____

GUARANTOR INFORMATION – IF DIFFERENT FROM ABOVE

Guarantor Name: _____ Relationship to Pt: _____

Address: _____ Apt #: _____ Marital Status: _____
City, State, Zip: _____ Home Phone # ( ) _____
Employer: _____ Phone # ( ) _____
Employer Address: _____

E-Mail Address: _____

Guarantor Social Security #: _____ Birthday: _____ Sex:____

INSURANCE INFORMATION

PRIMARY

Insurance Co Name: _____ Employer of Policy Holder: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Insurance Claim Address:_____
Insurance Claim Phone # _____ Policy Holder Birthdate: _____ Sex: ____
Insurance ID # _____ Group # _____ Effective Date: _____

Secondary Insurance Co Name: _____

ASSIGNMENT OF BENEFITS: I hearby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Private Insurance and any other health plan to The Dallas Center for Sleep Disorders. This agreement will remain in effect until revoked by me in writing. A photocopy 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 insurance 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:** _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand 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. Dr. Kakar and the providers of Dallas Sleep 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, Discover, American Express, Visa, or Mastercard

REGARDING INSURANCE:
Our office is pleased to assist you in filing claims with your insurance company for reimbursement of your medical expenses with us.

- *The patient is responsible to pay any deductible and co-payments prior to or at the time services are rendered.*
- *It is your responsibility to know if a referral is necessary for your visit.*
- *Any portion of a billed amount that is labeled "not allowed" or "not covered" will be the patient's responsibility. This is not the contractual obligation amount the physician will discount due to the practice's relationship with your insurance plan.*
- *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.*
- *If your insurance has not processed and paid your claim within 6 months, you will be responsible for the balance 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.*

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary.

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.

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.

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

_____ _____

Signature of patient or responsible party if patient is a minor *Date*

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Credit Card on File/ Automatic Billing Authorization Form

As a courtesy to our patients, Dallas Sleep is happy to accept assignment of your insurance benefits and do the insurance work for you. Dallas Sleep requires that all patients who pay only the estimated co-pay and have us wait for their insurance payment, leave a credit/debit card number on file with us.

Your card will only be charged for undisputed billing claims after your insurance has paid and there is any remaining balance.

This card and the card holder must be present at the office visit in order to verify card authenticity.

Please understand that, unless a pre-determination of benefits has been received for your specific services, Dallas Sleep can only ESTIMATE what your insurance will pay. While we are pleased to be of service by processing your medical claim for you, Dallas Sleep is not responsible for any limitations in coverage that may be included in your plan. If your insurance plan denies your claim for any reason, you will then become responsible for your bill in its entirety. It is your responsibility, as the patient, to pay any denied amounts in full.

If the actual insurance payment is less than the estimated amount, you will be notified by mail of the remaining balance due. If the remaining balance has not been received in full within 90 days of the date your insurance claim is filed, you are authorizing Dallas Sleep to charge this credit card for the remaining balance. Dallas Sleep will need to see the card and the ID to make sure the Name and numbers all match.

These charges include, but are not limited to DME, appointment visits, sleep study appointments, and late cancellations or missed appointments

Credit Card Pre-Authorization

Circle One VISA MC DISCOVER AMEX

Card# _____ Exp Date _____ CVV Code _____

Cardholder Name _____

Cardholder Signature _____

I have read and understand my obligations, and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier. I also agree that Dallas Center for Sleep Disorders cannot be held accountable for any NSF fees that may be charged to my account because of any charges to my credit card on file.

_____ _____

Patient Signature Date

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The Dallas Center for Sleep Disorders
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 information.

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 that relates to your past, present 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, we would disclose your PHI as necessary, to a durable medical equipment company 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 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 or authorization.

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 arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked o sign your name. We may also call you by name in the waiting room when your physician is ready to see you. 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 your 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 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

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Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** _____/_____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell:_____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: _____/_____/_____

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NO SHOW AND CANCELLATIONS

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:

$35 for clinic appointments

$250 for Sleep Study appointments

Please note that calls must be received during our regular business hours. Our hours are Monday – Friday, from 8 am to 5 pm.

Please know that your insurance company does not cover this charge. Repeated “no show” appointments could result in referring you back to your insurance company for reassignment to another specialist.

I understand that the office will make every attempt to place a reminder call for my appointments. However, whether or not a confirmation call is placed, I am still held responsible for remembering my appointment day and time.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

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Pediatric New Patient Registration & Medical Background Information

Ph: 972.473.7300 | Fax: 972-473-7750
6313 Preston Rd., Ste 400, Plano, TX 75024

PATIENT INFORMATION

Name: _____ DOB ___/___/___

CHIEF COMPLAINT: _____

SLEEP HISTORY

Usual Bedtime: during the week _____ ❑ AM ❑ PM on the weekends _____ ❑ AM ❑ PM

Usual Waketime: during the week _____ ❑ AM ❑ PM on the weekends _____ ❑ AM ❑ PM

Once the lights are out, how long does it usually take for your child to fall asleep? _____

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

Does your child snore? ❑ Yes ❑ No Does your child have a history of sleep walking or night terrors? ❑ Yes ❑ No

Does your child take naps during the day? ❑ Yes ❑ No

Does your child have a history of any of the following? *(Check if "YES" to any of the following)*

❑ GERD/ Reflux/ Heartburn ❑ Frequent Nightmares ❑ Frequent Ear Infections ❑ Restless Sleep ❑ Bed Wetting

❑ Nasal Allergies/ hay Fever ❑ Leg Pain/ Discomfort ❑ Asthma ❑ ADD/ADHD ❑ Orthodontic treatment

PAST MEDICAL HISTORY

1. _____ 3. _____

2. _____ 4. _____

PAST SURGICAL HISTORY

1. _____ 3. _____

2. _____ 4. _____

MEDICATIONS (including prescription and over-the-counter)

1. _____ 3. _____

2. _____ 4. _____

ALLERGY HISTORY (to any medications or substances)

❑ None Known ❑ YES, to: 1. _____ 3. _____

2. _____ 4. _____

SOCIAL HISTORY

Caffeine: ____ # of chocolate milk per day ____ of servings of chocolate per week ____ # of cups/glasses of tea per day

____ # of cups of coffee per day ____ # of servings of soda per day

Tobacco Exposure: ❑ None ❑ Yes _____ # of days per week

Living Situation: with both parents _____ with single parent _____ other _____

 # Of Siblings: _____ **Ages of Siblings:** _____

Pets: ❑ No ❑ Yes How many? _____ Do you have any pets that sleep in your child's bedroom? ❑ No ❑ Yes

FAMILY HISTORY

Does your child have any family history of medical illness:

❑ High blood pressure/hypertension ❑ Diabetes ❑ Stroke ❑ Snoring

❑ Restless legs syndrome ❑ Heart disease ❑ Sleep apnea

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REVIEW OF SYMPTOMS (ROS)

Constitutional:
Loss of Appetite: ❑ Yes ❑ No
Sweats: ❑ Yes ❑ No
Fever: ❑ Yes ❑ No
Fatigue: ❑ Yes ❑ No
Weight Gain: ❑ Yes ❑ No
Weight Loss: ❑ Yes ❑ No

Gastrointestinal:
Heartburn/Indigestion: ❑ Yes ❑ No
Black or Bloody Stools: ❑ Yes ❑ No
Diarrhea: ❑ Yes ❑ No
Nausea/Vomiting: ❑ Yes ❑ No
Jaundice: ❑ Yes ❑ No
Abdominal Pain ❑ Yes ❑ No

Allergy/Immunology:
Sneezing: ❑ Yes ❑ No
Runny Nose: ❑ Yes ❑ No
Itchy Eyes or Nose: ❑ Yes ❑ No
Hives: ❑ Yes ❑ No

Eyes:
Blurry Vision: ❑ Yes ❑ No
Double Vision: ❑ Yes ❑ No
Vision Loss: ❑ Yes ❑ No

Cardiac:
Palpitations: ❑ Yes ❑ No
Chest Pain: ❑ Yes ❑ No
Daytime Shortness of Breath: ❑ Yes ❑ No
Nighttime Shortness of Breath: ❑ Yes ❑ No
Ankle Swelling: ❑ Yes ❑ No

Skin:
Unusual Moles: ❑ Yes ❑ No
Rash: ❑ Yes ❑ No
Dryness: ❑ Yes ❑ No

Endocrine:
Weight Gain: ❑ Yes ❑ No
Heat Intolerance: ❑ Yes ❑ No
Excessive Thirst: ❑ Yes ❑ No
Constipation: ❑ Yes ❑ No
Cold Intolerance: ❑ Yes ❑ No

Respiratory:
Cough: ❑ Yes ❑ No
Shortness of Breath: ❑ Yes ❑ No
Wheezing: ❑ Yes ❑ No
Poor Exercise Tolerance: ❑ Yes ❑ No

Genitourinary:
Bed Wetting: ❑ Yes ❑ No
Frequent Urination: ❑ Yes ❑ No
Difficulty Urinating: ❑ Yes ❑ No
Blood in Urine: ❑ Yes ❑ No

Musculoskeletal:
Stiff/Sore Joints: ❑ Yes ❑ No
Muscle Pain: ❑ Yes ❑ No
Red or Swollen Joints: ❑ Yes ❑ No

Ears/Nose/Throat/Mouth:
Hearing Loss: ❑ Yes ❑ No
Sore Throat: ❑ Yes ❑ No
Sinus Congestion: ❑ Yes ❑ No
Hoarseness: ❑ Yes ❑ No

Neurologic:
Weakness: ❑ Yes ❑ No
Seizures: ❑ Yes ❑ No
Involuntary Tongue Biting: ❑ Yes ❑ No
Passing Out: ❑ Yes ❑ No
Dizziness: ❑ Yes ❑ No
Headaches: ❑ Yes ❑ No
Numbness: ❑ Yes ❑ No

Hema/Lymph:
Unexplained Weight Loss: ❑ Yes ❑ No
Unusual Bleeding/Bruising: ❑ Yes ❑ No
Swollen Lymph Nodes: ❑ Yes ❑ No

Psych:
Excess Stress: ❑ Yes ❑ No
Memory Loss: ❑ Yes ❑ No
Difficulty with Focus, or Concentration: ❑ Yes ❑ No
Hallucinations: ❑ Yes ❑ No
Nervousness or Anxiety: ❑ Yes ❑ No
Depressed Mood: ❑ Yes ❑ No

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THE EPWORTH SLEEPINESS SCALE

Name: _____

Your Age (Years): _____

Your Sex (Please Circle): ☐ M ☐ F

Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 – Would *never* doze
1 – *Slight* chance of dozing
2 – *Moderate* chance of dozing
3 – *High* chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (i.e. a theater or 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 lunch without alcohol	_____
In the car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation