Z SLEEP DIAGNOZTICS

Authorizations

Please review documents and Initial

_____ Financial Responsibility and Authorization of Benefits: I request that payment of authorized Medicare/other insurance company benefits be made to Z Sleep Diagnoztics, LLC for services/treatment provided to me. I hereby assign to Z Sleep Diagnoztics, LLC all insurance benefits and payments to which I am entitled from whatever source for services/treatment provided by Z Sleep Diagnoztics, LLC. If I have no coverage in effect, or payment is denied by my insurance, then I assume all responsibility of payment due to Z Sleep Diagnoztics, LLC for services rendered. I acknowledge that Z Sleep Diagnoztics, LLC supplies the technical component of this sleep study **and that a separate physician will bill for the interpretation.**

_____ Release of Information: I authorize any holder of medical or other information about me to release to Z Sleep Diagnoztics, LLC any information requested by them for treatment, payment or healthcare operations. I permit a copy of this authorization be used in place of the original.

_____ Consent to Diagnostic Procedure and Video Consent and Release I have been provided with and reviewed the consent to diagnostic procedure release.

_____ Acknowledgement and Review/Receipt of Privacy Practices I have been provided a copy of the Notice of Privacy Practices of Z Sleep Diagnoztics, LLC and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The document describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Z Sleep Diagnoztics, LLC. Z Sleep Diagnoztics, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the practices by calling the office at Z Sleep Diagnoztics, LLC and requesting a revised copy be sent in the mail.

_____ Patient Rights and Responsibilities

Print Name _____

Signature _____ **Date** _____

Signature of Witness _____ **Date** _____

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Diagnostic Equipment Agreement

Patient: _____ DOB: _____ Phone: _____

Return by Date: _____ Cost of Equipment Issued: __$1,900.00___

Device Serial Number:

#_____

I _____ understand that I am receiving a loaner device(s) which will enable Z Sleep Diagnoztics, LLC to make diagnostic determinations related to my treatment. I authorize Z Sleep to charge my Credit Card for $150 (per loaner device) if I do not return the equipment by the return date. I understand that I am still responsible for the entire cost of the supplied equipment.

_____

Credit Card # Exp Security Code Zip Code

_____ _____

Patient Signature and Date Print Name

_____

Witness Signature and Date

Z Sleep Diagnoztics

4201 Anderson Ave Ste D 120

Manhattan, KS 66503

785-537-1130

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Home Sleep Testing Device

1. Go to www.youtube.com to watch the Alice Night One Patient Setup video by Philips Healthcare.
2. To turn the device on, plug in both ends of the belt to the device. This will start the recording automatically. DO NOT touch the white button on the front of the device to start it.
3. To turn the device off at the end of the testing session, unplug the belt from the device. After 30 minutes, the device will shut off on its own.
4. ***If you get up in the middle of the night for any reason, leave the device on and recording. Do not take it off.***
5. Try to wear the testing device for at least 6 hours, if not, longer.
6. The lights (icons) do not stay lit all night. The light at the end of the finger will stay illuminated in red all night with a proper connection. You may wear this on whatever finger feels best.
7. You may briefly touch the white button on the front of the device at any time to turn on the lights to check the device's connections. DO NOT hold down the button, as it could shut off the device.
8. If you do not bring the testing device back the next day, or do not drop it in the mail the next day, please contact the sleep lab to let them know why you will not be returning it the next day to avoid late charges.

QUESTIONS OR CONCERNS?

Give us a call!

785-537-1130

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To be completed the morning after your study.

Name: _____

Date of Birth: _____

1. What time did you go to bed? _____
2. How long did it take you to fall asleep? _____
3. How many times did you get out of bed once going to sleep? _____
4. How long do you think you slept? _____
5. What time did you get out of bed to start your day? _____
6. If there is anything extra you would like us to know please document:

I hereby confirm that the Alice NightOne device provided to me by Z Sleep Diagnoztics was worn by me on _____ (DATE).

_____ _____

Signature Date

Patient Name: _____ Z SLEEP DIAGNOZTICS Date Of Birth: _____

Pre-study Questionnaire

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
0= would never dose 1= slight chance 2= moderate 3= high

_____ Sitting and reading
_____ Watching TV
_____ Sitting, inactive in a public place
_____ As a passenger in a car for more than an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking with someone
_____ Sitting quietly after lunch without alcohol
_____ In a car, while stopping for a few minutes in traffic

_____ **Total**

Sleep Schedule

What time do you go to bed on **weekdays**? _____ AM or PM
What time do you get up on **weekdays**? _____ AM or PM
What time do you go to bed on **weekends**? _____ AM or PM
What time do you get up on **weekends**? _____ AM or PM

Do you take naps? ☐ yes ☐ no
If yes, how often do you nap?
_____ times per week

Are you a shift worker? ☐ yes ☐ no If yes, what kind of shift do you work? _____

Check for each problem you *currently have*:

☐	loud snoring	☐	teeth grinding
☐	frequent awakenings at night	☐	morning headaches
☐	choking for breath at night	☐	morning dry mouth
☐	I've been told I stop breathing when asleep	☐	sleep walking
☐	leg-kicking during sleep	☐	sleep terrors
☐	crawling feeling in legs when trying to sleep	☐	tongue biting in sleep
☐	trouble falling asleep	☐	bed wetting
☐	trouble staying asleep	☐	acting out dreams
☐	fear of being unable to fall asleep	☐	feeling paralyzed when falling asleep
☐	racing thoughts when trying to sleep	☐	dreamlike images when falling asleep
☐	waking too early	☐	uncontrollable daytime sleep attacks
☐	sweating a lot at night	☐	falling asleep unexpectedly
☐	waking up with heartburn	☐	falling asleep at work
☐	waking up to urinate	☐	falling asleep while driving
☐	nightmares	☐	I use sleeping pills to aid in sleep
☐	muscle tension when trying to fall asleep	☐	I use alcohol to help me sleep
☐	pain interfering with sleep	☐	I get "weak knees" when I laugh

Patient Name: _____

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Date Of Birth: _____

Please list hospitalizations within the last five years.

Reason for hospitalization: Date

1. List your current average for each category:

_____ cups of regular coffee per day
_____ cups of tea per day
_____ ounces of soda or other caffeinated beverage per day
_____ cans of beer per day (12 oz)
_____ glasses of wine per day
_____ alcoholic drinks per day (1-2 oz straight or mixed)

2. Do you use tobacco products? ☐ Yes ☐ No ☐ Quit (How long ago_____months/years)

If so, how much per day? _____

3. What is your relationship status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone

4. What is your occupation?

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History and Physical

Patient Name: _____ Age: _____ Sex: _____

Height: _____ Weight: _____

Presenting Symptoms

- ☐ Snoring
- ☐ Difficulty Sleeping
- ☐ Observed Apneas
- ☐ Excessive Daytime Sleepiness
- ☐ Memory Loss
- ☐ Other _____
- ☐ Hypoxia
- ☐ Choking/Gasps During Sleep
- ☐ Leg Restlessness
- ☐ Falling asleep while driving

Health History

- ☐ Diabetes
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Acid Reflux
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Heart Disease or CHF
- ☐ Thyroid Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Emphysema or COPD
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Tuberculosis
- ☐ Head Trauma
- ☐ Severe Headaches
- ☐ Epilepsy
- ☐ Runny or blocked nose
- ☐ Fainting
- ☐ Hormonal Problem
- ☐ Depression
- ☐ Urological Problem
- ☐ Anxiety Disorder
- ☐ Problems w/alcohol
- ☐ Problems w/Drugs

Medications: (use back if needed)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____

Supplemental Oxygen _____**LPM**

Do you currently use CPAP at home? ☐ **Yes or** ☐ **No**

If Yes: Pressure _____ **Mask type**_____ **Years**_____

Special Needs

- ☐ **Wheelchair**
- ☐ **Incontinence**
- ☐ **Walker/Cane**

Z SLEEP DIAGNOZTICS

Office Use Only

Information obtained by: _____ Scheduled Test Date: _____

Approved for PSG/Titration/MSLT/HST by: _____ Date: _____