New Patient Sleep Packet

To our Patients,

We would first like to thank you for choosing West Coast Neurology as one of your health care providers. Providing you with the best possible experience is very important to us, and in order to do so we have created this packet to speed up the process once you step through our doors. Attached is paperwork on what to expect during your sleep study and how you should prepare for it. As well, there are waivers and a questionnaire to help the doctors get a deeper understanding of the problems you are having and how to better treat them. You can obtain more information about sleep disorders and what to expect during a test from our website at www.WestCoastNeurology.com.

We pride ourselves in providing the highest level of service and care through every step of the process including: testing, diagnosing, and treating sleep disorders at West Coast Neurology should you require treatment.

Please feel free to contact West Coast Neurology Pediatric and Adult Neurodiagnostic Center staff with any questions about your upcoming study.

Sincerely,

West Coast Neurology

Your appointment is scheduled for:

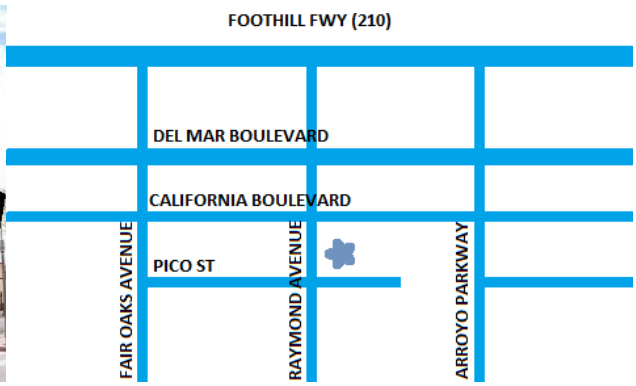
Date:_____ TIME: _____

West Coast Neurology, Inc.
Pediatric and Adult Neurodiagnostic Program
630 S Raymond Ave Suite 310, Pasadena, CA 91105 | Bus: (626) 598-3770 | Fax: (626) 598- 3797

You have been scheduled for a sleep study at the
West Coast Neurology Pediatric and Adult Neurodiagnostic Center.

When you arrive:

The Technician will meet you in front of the gates to the parking garage (off Pico St.) at the time of your scheduled study. Please stay in your vehicle until your technician arrives to give you access to the parking garage. If your do not see your technician, please call them at (626) 765-4163 to let them know you have arrived.



Location: 630 South Raymond Ave Suite 310 Pasadena CA 91105
Cross Streets: California Blvd between Fair Oaks Blvd and Arroyo Parkway

Patient Instruction Sheet

- No caffeine after 9 am the day of the test
- Eat dinner before you arrive (we do have snacks and caffeine-free drinks)
- Bring your insurance card
- You may bring your own pillow although pillows and blankets will be provided.
- Bring comfortable clothing (NO SILK or SATIN)
- Your hair should be clean and free of any styling products (i.e. gels, hairsprays, creams, etc.)
- Electrode gel will be used to adhere leads to your scalp.
- Bring any medications you regularly take at night, including your sleep medications
- Departure time is around 6-7 am; please tell the technicians if you need to leave earlier

WHAT TO EXPECT

Upon your arrival you will be greeted by a technician who will escort you to your room. The technician will explain the procedure and what to expect during the night. Electrode gel will be used to adhere leads to lower legs, chest, head and face; this washes off easily with water. Wake up time is between 6 and 7 am.

ITEMS TO BRING FOR YOUR SLEEP STUDY

Please review the list below and feel free to ask our center team if you have any questions:

ITEMS TO BRING:

- Driver's License
- Insurance Card
- Medication
- Medication List
- Light Overnight Bag
- 2 Piece Pair of Pajamas
- Toothbrush\ Mouthwash
- Personal Hygiene Products

DO NOT BRING:

- Valuable jewelry or large sums of money
- Strong Perfumes or Cologne
- Alarm Clock (we will wake you up)

ITEMS & SERVICES WE PROVIDE

- Free Secure Parking
- Reading Lamp
- Registered Technicians
- Bi-Lingual Staff
- Private Room for your Caretaker (If Needed)
- Bathroom
- Washcloths/Small Hand Towel

Please let us know if you have any disabilities or special needs that we should know about prior to your study. Due to the gel we use to attach each lead, you will need to wash your hair following the study. If there is anything else, we can do to make your stay more enjoyable, do not hesitate to ask. We want to provide you with the best experience possible!

Sincerely,
West Coast Neurology

West Coast Neurology, Inc.

Pediatric and Adult Neurodiagnostic Program

630 S Raymond Ave Suite 310, Pasadena, CA 91105 | Bus: (626) 598-3770 | Fax: (626) 598- 3797

Patient Name: _____

DOB: _____Cell Phone:_____Home Phone: _____

Email: _____

Street Address: _____

City: _____State:_____Zip Code:_____

Sex: M □ F □ Age _____ Height:_____ Weight:_____

Occupation:_____Race/Ethnicity:_____ Langauge:_____

Emergency Contact: _____ Phone #: _____

Referring Physician: _____

Patient Agreement	**Assignment and Release** **I, understand, have insurance coverage with_____, and assign directly to West Coast Neurology all medical benefits, if any. Otherwise payable to me for services rendered that I am financially responsible for all charges whether paid or not paid by insurance I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions.** **_____ _____** **Signature of insured/ Guardian Date**
Workers Compensation/Auto Insurance Information	****Only if Work/ Accident Related**** **Date of Injury: _____** **Insurance Company Name: _____** **Address:_____Phone: City:** **_____State:_____Zip:_____** **Adjuster:_____ Claim #: _____**

West Coast Neurology, Inc.
Client/Patient Rights and Responsibilities

- You have the right to be fully informed in advance about care/service to be provided, including the disciplines that furnish care and the frequency of visits, as well as any modifications to the plan of care (SLC2-1A)
- You have the right to be informed, in advance, both orally and in writing, of care being provided, of the charges, including payment for care/service expected from third parties and any charges for which the client/patient will be responsible (SLC3-4A)
- You have the right to be informed about the scope of services that the organization will provide and specific limitations on those services (SLC2-1A)
- You have the right to refuse care or treatment after the consequences of refusing care or treatment are fully presented (SLC2-2B)
- You have the right to have property and person treated with respect, consideration, and recognition of client/patient dignity and individuality (SLC2-2B)
- You have the right to be able to identify personnel members through proper identification (SLC2-2B)
- You have the right to be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of client/patient property (SLC2-3A)
- You have the right to voice grievances/complaints regarding treatment or care, lack of respect of property or recommend changes in policy, personnel, or care/service without restraint, interference, coercion, discrimination, or reprisal (SLC2-4A)
- You have the right to have grievances/complaints regarding treatment or care that is (or fails to be) furnished or lack of respect of property investigated (SLC2-4A)
- You have the right to be have confidentiality and privacy of all information contained in the client/patient record and of Protected Health Information (PHI) (SLC2-5A)
- You have the right to be advised on agency's policies and procedures regarding the disclosure of clinical records (SLC2-5A)
- You have the right to choose a health care provider, including an attending physician (SLC2-2B)
- You have the right to receive appropriate care without discrimination in accordance with physician orders (SLC2-2B)
- You have the right to be informed of any financial benefits when referred to an SLC (SLC2-2B)
- You have the right to be fully informed of one's responsibilities (SLC2-2B)

West Coast Neurology

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 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

_____

Date

February 1, 2019

Notice Effective Date or Version

West Coast Neurology Use Only

West Coast Neurology
630 S Raymond Ave Ste 310
Pasadena, CA 91105
626-598-3770

Written Financial Policy

Thank you for choosing West Coast Neurology. 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

West Coast Neurology 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 626-598-3770.

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.

Patient, Parent or Guardian Signature Date

Signature Obtained on Acknowledgement of Receipt From

_____

Patient Name (Please Print)

West Coast Neurology
Acknowledgement of Receipt Form

West Coast Neurology
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 West Coast Neurology 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

West Coast Neurology 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 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 a representative 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 complaints. Our office number is **626-598-3770.**

To file a grievance or complaint you can contact:

Carlos Becerra, Esq.
Compliance Officer for West Coast Neurology
626-598-3770
cbecerra@westcoastneurology.com

Accreditation Commission for Health Care
139 Weston Oaks Ct.
Cary, NC 27513
Toll-Free: (855) 937-2242
Local: (919) 785-1214
Fax: (919) 785-3011
customerservice@achc.org

Medicare Beneficiary and Family Centered Care Quality Improvement Organization
Toll Free: (877) 588-1123
TTY: (877) 588-1123

California State Medical Board
Phone: 850 325-1400 / 866 776-3555
Fax: 850 877-6417
Email: license@californiamedlicense.com

West Coast Neurology, Inc.
Acknowledgement of Receipt Form

By my signature below I acknowledge that I have received the below forms /policies and have had an opportunity to review these documents with West Coast Neurology 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
- How to file a complaint/grievance

I hereby authorize West Coast Neurology 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 West Coast Neurology 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:_____

Printed Name:_____ Date:_____

Staff Signature:_____ Date:_____

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

_____

SLEEP QUESTIONNAIRE

PLEASE COMPLETE IN BLUE OR BLACK INK

The following questionnaire is designed to help aid our sleep specialist in providing the best care possible. We ask that you please answer all questions as accurately as possible; even if they do not pertain to your specific individual case.

PLEASE COMPLETE THE QUESTIONNAIRE BEFORE YOUR APPOINTMENT. THANK YOU.

Printed Name:_____ DOB:_____

West Coast Neurology, Inc.

Pediatric and Adult Neurodiagnostic Program

Patient's Sleep History	
Have you previously had a sleep study?	• Yes / • No
If yes, where and when was the study done?	
In your words describe your major concern (s) about your sleep, including when and how this began and what treatment you have received in the past.	

SLEEP SCHEDULE:

Weekdays:_____am/pm _____am/ pm _____hours

Weekends:_____am/pm _____am/ pm_____hours

Do you wake up feeling rested? • YES / • NO

Do you currently use CPAP treatment at night?• YES/ • NO
If so what pressure:

Do you have rotating or night shift work?• YES/ • NO

How long does it take you to go to sleep?_____Hours _____Minutes

How many times a night do you wake up from sleep?_____

Do you fall back to sleep easily? • YES/ • NO

Do you nap? • YES/ • NO

If so, how often and how long?

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in certain situations, in contrast to just feeling tired?

This refers to your usual way of like in recent times, if you have not done some of these things recently, think about how they have affected you in the past.

Use the following scale to choose the most appropriate number for each situation

0= no chance of dozing
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

It is important to answer each question as best as you can

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading or watching TV	___	___	___	___
Sitting, inactive in a public place	___	___	___	___
As a passenger in a car for an hour	___	___	___	___
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	___	___	___	___

Printed Name:_____ DOB:_____

Printed Name:_____ DOB:_____

SLEEP HISTORY:

☐YES ☐NO	Do you feel excessively tired during the day?	How often? _____
☐YES ☐NO	Are you a restless sleeper?	
☐YES ☐NO	Have you been told you snore?	How often? _____
☐YES ☐NO	Have you ever been told you quit breathing at night?	How often? _____
☐YES ☐NO	Have you ever awakened gasping for breath?	How often? _____
☐YES ☐NO	Do you have dry mouth in the morning?	How often? _____
☐YES ☐NO	Do you have morning headaches?	How often? _____
☐YES ☐NO	Has your weight fluctuated over the past 3 years?	How much? _____
☐YES ☐NO	Do you have "tingly" legs/ feel as if you have to move them?	For how long? _____
☐YES ☐NO	Do you kick your legs at night?	For how long? _____
☐YES ☐NO	Do you grind your teeth in your sleep?	How often? _____
☐YES ☐NO	Do you talk in your sleep?	For how long? _____
☐YES ☐NO	Do you have difficulty staying awake when driving?	For how long? _____
☐YES ☐NO	Have you ever had a motor vehicle accident due to sleepiness?	
☐YES • NO	Have you ever had a hallucination or dream-like mental images when falling asleep?	
☐YES • NO	Have you ever experienced weak knees during emotions like laughing, happiness, or anger?	
	How often? _____	
☐YES • NO	Have you ever experienced sagging of the jaw during emotions like laughing, happiness, or anger?	
	How often? _____	

Printed Name: _____ DOB:_____

PAST MEDICAL HISTORY:

Please check all that apply:

☐Hypertension	☐Emphysema	☐Diabetes	☐Sinus Disease
☐Heart Disease	☐COPD	☐Neuropathy	☐Nasal surgery
☐CHF	☐Asthma	☐Migraines	☐Bed Wetting
☐Cardiac Bypass	☐Pulmonary Disease	☐Ulcers	☐Thyroid Disease
☐Pace Maker	☐Seizures	☐High Cholesterol	☐Acid Reflux

☐Other: _____

CURRENT MEDICATIONS AND DOSING INSTRUCTIONS:

_____
_____
_____
_____

Drug Allergies:_____

Do you use supplemental oxygen? • YES • NO
If yes,_____liters/minute

Caffeine Use: • Soda Pop • Tea • Coffee How many cans/cups per day? _____

Tobacco Use: • Never • Currently Smoke • Quit • Currently Dip
How many packs per day? _____

Home: ☐Married ☐Widowed ☐Divorced • Single •Legally Separated

Alcohol: ☐Never ☐Socially ☐Daily ☐Sober

Illicit Drugs: ☐Never ☐Occasionally ☐Daily ☐Quit

Work: ☐Retired ☐Disabled ☐Student ☐Employed •Part-time
•Shift work •Night shift

FAMILY HISTORY: *(Father, mother, brother, and or sister):*

	Person with disorder		*Person with disorder*
☐Diabetes	_____	☐Narcolepsy	_____
☐Hypertension	_____	☐Snoring	_____
☐Stroke	_____	☐Depression	_____
☐Obesity	_____	☐Daytime Fatigue	_____
☐Sleep Apnea	_____	☐Migraines	_____

Printed Name: _____ DOB: _____

Review of Systems:

Please circle or check all that apply

Constitutional Review: • Fever/ • Night Sweats/ • Unexplained weight loss/ • Unexplained weight gain

Ear, Nose, and Throat Review: • Hearing Loss/ • Tinnitus/ • Trouble Swallowing/ • Nasal Congestion

Pulmonary Review: • Coughing/ • Shortness of breath/ • Wheezing/ • Coughing up blood/ • Difficulty breathing lying flat

Musculoskeletal Review: • Muscle ache/ • Joint pain

Endocrine Review: • Excessive thirst/ • Unusually moist or dry skin/ • Heat intolerance/• Cold intolerance

Psychosocial/Social Review: • Loss of appetite/ • Feeling depressed or down/ • Anxiety/ • Agitation/ • Increased stress

Cardiac Review: • Chest pain/ • Ankle Swelling/ • Heat Murmur

GI Review: •Black stools or bleeding from bowels/ • Nausea/ • Vomiting/ • Abdominal Pain

BU Review: • Frequent bladder infections/ • Painful urination/ • Frequent urination/ •Blood in urine

Skin Review: • Skin rash/ • Easy bruising

Neurological Review: • Trouble with balance/ • History of stroke/ • Seizure/• Difficulty concentrating/ • Headaches/ • Migraines/ • History of Restless legs

Other Complaints not mentioned:

_____

_____

_____ _____ _____

Patient Signature Print Name Date

_____ _____

Physician signature Date