OUT OF CENTER SLEEP TESTING (OCST)

CONSENT

Details

You will undergo a modified type of sleep study known as an Out of Center Sleep Test or Portable Monitoring Sleep Test. This represents an abbreviated version of traditional sleep tests in which a patient is monitored by a technician. In this version the patient is under NO supervision and would pick up monitoring equipment and test in his/her own home. This form of test also monitors fewer parameters then the traditional test. Parameters are as follows:

* Oxygen level * Breathing rate * Airflow * Heart rate * Body Position

The sleep center will use this information to prepare a detailed report about your sleep. This report will then be forwarded to your referring physician. Your physician will discuss the results with you.

Agreement

"I UNDERSTAND . . . . ."

1. That this abbreviated sleep test may not detect the cause of my sleep problem.
2. I will attach sensors to my body for the study.
3. The removal of the sensors in the morning may irritate my skin and cause redness.
4. I am solely responsible for any allergic reactions that I may experience that result from my failure to inform sleep lab.
5. I will be free to roll over and move in bed during the study.
6. I need at least 6 hours of recording time in order to get sufficient monitoring data.
7. I understand that I will be responsible for making sure that I turn "ON" the equipment at the beginning of my study and turn it "OFF" at the end of my study.
8. If I should decide to end my test prior to the 6 hours needed I understand that this will be against medical advice and orders given by my doctor and may render my test non-diagnostic.

By signing below, I agree to and understand the terms stated above.

_____		_____
Patient Name (Print)		Date
_____	_____	_____
Signature (Patient or Guardian)	Relationship to Patient	Date
_____		_____
Witness		Date

OUT OF CENTER SLEEP TESTING (OCST)

PATIENT RIGHTS & RESPONSIBILITIES

Texas law requires that health care providers or healthcare facilities recognize patient rights while receiving medical care and that the patient respect the healthcare provider's or healthcare facility's right to expect certain behavior on the part of patients. The patient may request a copy of the full text of this law. A summary of rights and responsibilities follow:

A PATIENT HAS THE RIGHT TO:

- Be treated with courtesy and respect, with appreciation of his/her individual dignity, and with protection of his/her need for privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for his/her care.
- Know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- Be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- Who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- To express grievances regarding any violation of his/her rights, as stated in Texas law, through the grievance procedure of the healthcare provider or health care facility, which served him/her, and to the appropriate state-licensing agency.

A PATIENT IS RESPONSIBLE FOR:

- Providing to the healthcare provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- Reporting unexpected changes in his/her condition to the healthcare provider.
- Reporting to the healthcare provider whether he/she comprehends a contemplated course of action and what is expected of him or her.
- Following the treatment plan recommended by the healthcare provider.
- Keeping appointments and, when he/she is unable to do so for any reason, for notifying the healthcare provider or health care facility.
- His/her actions if he/she refuses treatment or does not follow the healthcare provider's instructions.
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible.
- Following healthcare facility rules and regulations affecting patient care and conduct.

OUT OF CENTER SLEEP TESTING (OCST)

PATIENT RESPONSIBITIES FOR OCST

_____ Initial — Patient agrees to return the equipment in the condition at time of Check-Out (GOOD).

_____ Initial — Patient agrees to use the equipment with care, and understands that equipment is **NOT** to be altered nor modified in any way.

_____ Initial — Patient agrees to use the equipment ONLY as indicated and in compliance with Physician's orders.

_____ Initial — Patient promises to keep all equipment in their possession at all times.

_____ Initial — Patient agrees to pay the cost of any equipment damaged, destroyed, lost or stolen due to patients' misuse, abuse or neglect.

_____ Initial — Patient agrees to promptly report any malfunctions or defects to the equipment in a timely manor so that repairs and/or replacements can be arranged.

_____ Initial — Patient agrees to notify San Antonio Sleep Centers of any sudden changes in health, hospitalization and/or any change in insurance, address, or telephone number.

_____ Initial — Patient agrees to request payment of authorized benefits from Medicare, Medicaid, or other private insurance to be paid directly to San Antonio Sleep Centers for the services provided.

_____ Initial — Patient agrees to return all equipment on the day after the sleep test. Failure to do so will result in a late fee of $100 per day until all equipment is returned.

_____ Initial — A credit card number is required as a deposit at time of Checkout. (No charges will be made the credit card unless equipment is not returned or damaged.)

I have read the Patients Responsibilities and I agree to all the terms as stated above.

_____ Patient Name (Print) _____ Date

_____ Signature (Patient or Guardian) _____ Relationship to Patient _____ Date

_____ Witness _____ Date

OUT OF CENTER SLEEP TESTING (OCST)

SLEEP QUESTIONNAIRE

Patient Information (Please Print)

Last Name: _____ First Name: _____MI_____

Date of Birth_____ Age: _____ Social Security #: _____

Height: _____ Weight: _____ Sex (Circle) Male or Female

Address: _____ City: _____

State: _____ Zip Code: _____ Drivers License #: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Emergency Contact: _____ Ph: _____

Referring Physician: _____ Family Physician: _____

Reason for visit: __OCST___ Diagnosis: _____

INSURANCE INFORMATION

Primary

Insurance: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Phone: _____

Secondary

Insurance: _____

Policy #: _____ Group #: _____

Subscriber Name: _____ Phone: _____

OUT OF CENTER SLEEP TESTING (OCST)

Please complete these questions as thoroughly as you can. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE.

1. Describe your main problem (s) including when and how this began, what physician have you seen, and any treatment you have received for this in the past.

   _____

   _____

2. Do you take any kind of medication? Yes_____ or No_____

   If yes, what kind: _____

   Amount: _____ How often: _____

   Reason: _____

3. List your consumption of the following on a daily basis:

   A. COFFEE: _____
   B. TEA: _____
   C. ALCOHOL: _____
   D. NICOTINE: _____
   E. CAFFEINE: _____

4. List any surgeries or major illnesses:

   _____

   _____

5. Please circle Yes or No to the following:

A.	Snore	Yes	No
B.	Snore loudly enough that others complain	Yes	No
C.	Wake up gasping for breath during the night	Yes	No
D.	Awaken at night with heartburn, belching coughing Or wheezing.	Yes	No
E.	Fall asleep during the day	Yes	No
F.	Fall asleep while driving	Yes	No
G.	Trouble at school or work due to sleepiness	Yes	No
H.	Fall asleep involuntarily	Yes	No
I.	Fall asleep during physical effort	Yes	No
J.	Fall asleep when laughing or crying	Yes	No

OUT OF CENTER SLEEP TESTING (OCST)

K.	Cataplexy: Experience loss of muscle tone when extremely emotional	Yes	No
L.	Feel unable to move (paralyzed) when waking Up or falling asleep	Yes	No
M.	Experience vivid, dream like scenes upon Waking up or falling asleep	Yes	No
N.	Sweat excessively during the night	Yes	No
O.	Notice your heart pounding or beating irregular During the night	Yes	No
P.	Notice that parts of your body jerk	Yes	No
Q.	Kicking during the night	Yes	No
R.	Experience crawling and aching feeling in your legs	Yes	No
S.	Experience any type of leg pain during the night	Yes	No
T.	Insomnia	Yes	No
U.	Frequent Awakenings	Yes	No
V.	Headaches	Yes	No
W.	Impaired Cognition	Yes	No
X.	Witnessed Apneas	Yes	No
Y.	Sleep Walking	Yes	No
Z.	Supine Capable	Yes	No

Previous sleep study Yes No

Date: _____ Sleep Lab: _____ Dx: _____

Medical Conditions

□ CHF □ Stroke/MI □ Parasomnias □ RLS/ PLMD □ Hypertension □ Chronic pain

□ Seizures □ Asthma/COPD □ Nocturia/Enuresis □ Anxiety/PTSD □ Depression

□ Diabetes □ GERD/Acid Reflux □ Cardiac arrhythmias □ Hysterectomy □ Cancer

Major diseases or disorders: Yes or No, Explain: _____

BMI:_____ Allergies to medication? _____

Surgeries: _____

OUT OF CENTER SLEEP TESTING (OCST)

HIPAA

Release:
I hereby authorize San Antonio Sleep Centers to release my Physical Health Information (PHI) Acquired in the course of my examination; including but not limited to sensitive material from my medical history to my insurance company for payment, continued health care with the following: primary care physician, sleep specialist, consultant physicians involved in my care with durable medical equipment facilities, my self, and when required by federal and state laws as described in the Notice of Privacy Practices given to me at the time of my instructions for examination. I _____ understand that San Antonio Sleep Centers is in complete compliance with all laws and regulations of the Health Insurance Portability and Accountability Act (HIPAA).

I authorize San Antonio Sleep Centers to send me my physical health information (PHI) by the Following:

Email: _____

Address: _____
Street City State Zip Code

Accept my electronic signature

Signature: _____ Date: _____

**** Contact San Antonio Sleep Centers Privacy officer if you have any questions, concerns or complaints @ (210) 614 – 7474.***

Payment:
I understand that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility.

- If I receive payment for services directly from my insurance, I agree to will forward the total amount to SASC.
- I am aware that ALL NSF checks will be forwarded to the District Attorney's Office, and my account will be turned over to a collection agency.
- I authorize charges on my credit card on file for unpaid fees (ONLY).
- I agree that my liability for this bill is not waived and agree to be held personally liable in the event my insurance company fails to pay the full amount of these charges.

_____ _____
Patient Name (Print) Date

_____ _____ _____
Signature (Patient or Guardian) Relationship to Patient Date

OUT OF CENTER SLEEP TESTING (OCST)

EQUALITY ASSURANCEIPMENT CHECK LIST

EQUIPMENT	CHECKOUT	RETURN
Portable Monitoring Device & Case **Serial No.: _____** (Respironics Stardust)	Condition: Initial:	Condition: Initial:
Belt Sensor	Condition: Initial:	Condition: Initial:
Pulse Oximeter Finger Probe	Condition: Initial:	Condition: Initial:
Nasal Pressure Sensor	Condition: Initial:	Condition: Initial:

I _____ have received all equipment as listed above. I agree that all equipment is presented to me in good condition. I agree to return all equipment listed in the condition received.

_____

Patient Name (Print) Date

_____ _____

Signature (Patient or Guardian) Relationship to Patient
Date

OUT OF CENTER SLEEP TESTING (OCST)

_____ _____
Witness Date

FOR OFFICE USE ONLY

SCORING: End Time: _____

Respiratory: _____ Other: _____

Dictated: _____ Reviewed: _____

Pick-Up / Check-Out

Monday – Thursday
(Except major holidays)

8:00am - 4:00pm

Drop-Off / Check-In

Tuesday – Friday
(Except major holidays)

8:00am - 3:00pm

Scheduled Drop-Off Date: _____ Time: _____

** Note:*

OUT OF CENTER SLEEP TESTING (OCST)

If equipment is not returned the day after the sleep test (Date agreed to and stated above), a late fee of $100.00 per day will be charged to credit card on file. These fees are not covered by insurance.

Equipment Malfunction	(210) 213 – 7663
Questions / Concerns	(210) 213 – 7663
Emergency	911

PRE/POST SLEEP QUESTIONAIRE

Name: _____ DOB: _____ Date: _____ Record: _____

PRE-SLEEP

1. Did you take any naps today? _____ How Long? _____

2. Have you taken any medication today? □ Yes □ No

(List ALL medication both prescription and no-prescription)

Medication	Dosage	Time Taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

3. Have you had any caffeinated or alcoholic drinks today? _____ Yes _____ No
   If yes, what, when and how much? _____

4. Did anything out of the ordinary happen today? □ Yes □ No
   If yes, what? _____

5. Did you feel sleepy today? □ Yes □ No _____am _____pm

6. How tired do you feel right now? □ Not at all □ a little □Quite a bit □Extremely

STOP

POSTSLEEP

1. How long did it take you to fall asleep last night? _____
   Compared to usual, was it □ Harder □ Same □ Easier to fall asleep?

2. Did you have any difficulty falling asleep last night? □ Yes □ No

3. Did you wake up during the night? □ Yes □ No
   If yes, how many times? _____

4. How long did you sleep last night? _____
   Compared to usual was it □ Longer □ The same □ Shorter?

5. How did you feel upon awaking? □ More rested □ less rested □ about the same

6. How tired do you feel right now? □ Not at all □ A little □ Quite a bit □Extremely

7. How did the quality of your sleep last night compare to your sleep without the apparatus? Include any comments you may have about how we can improve your stay in our lab.
   _____

ON-CALL EMERGENCY & COVERAGE POLICY

PURPOSE:
Establish specific criteria and methods for Out of Center Sleep Testing On-Call procedures.

POLICY:
Upon adverse, unexpected situations, the patient will stop any and all procedures and contact the appropriate support listed below.

1. **Call 911 for medical emergency.**
2. **Call the "On-Call" OCST technician for technical issues.**
3. **Call (210) 614-7474 to dispatch support.**

PROCEDURE: The On-Call OCST support will ask the following:
- Are you having a technical problem?
- Or, Do you have a medical condition?

If technical, the technician will attempt to correct issue by phone.

CALL: (210) 614 – 7474 to dispatch support.
OR
(210) 213 – 7663 the "On-Call" Supervisor

If Medical Emergency: CALL 911.

If medical [other], report any of the following to the medical professional on-call:

- Feeling of severe anxiety towards taking therapy.

- If you completely refuse to take therapy.

• If you become unexplainably upset during the therapy.

Undesirable side effects are considered any sudden unexplained deterioration of your condition due to medications or therapeutic procedures and should be handled as follows:

Stop procedure immediately if:

a. Chest pain.
b. Extreme anxiety.

REMEMBER: This is a unattended / unsupervised evaluation
If EMERGENCY CALL: 911

SAN ANTONIO SLEEP CENTERS

* Medical Center *

"Committed to helping people live better and more productive lives."

Payment Collection Agreement

Patient Name: _____ Pt Initials: _____

Date of Service: _____ Sleep Lab Location: _____

Amount Collected: _____

Please select the payment option:

☐ Cash - - - - - - - $ _____ (Make copy of cash and attach to this form)

☐ Check #_____ $_____

☐ Post-Dated Check(s) 1st Ck #_____ $ _____ 2nd Ck # _____ $_____

Mandatory: (Will also be used for late fees and damages if applicable)

☐ Bank Card **Type:** MC/Visa Discover Debit American Express

Card #: _____ (Make copy of card. Front & Back)

Expires: _____ Security Code: _____ Billing Zip Code: _____

* _____
Patient Signature

☐ Other: _____
Explain: _____

OUT OF CENTER SLEEP TESTING (OCST)

Special Instructions:

*** All payment arrangements with postdated checks must be secured with a valid credit card number. No charges will be made to the credit card unless a check is returned with insufficient funds. Charge will be made for total amount on check plus, returned check fee ($35).

Technician: _____ (Please Print) Date: _____

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

General Information

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA")*, and the Confidentiality Law*. Under these laws the Sleep Centers are not allowed to disclose any protected information except as permitted by the federal laws referenced below.

** 42 U.S.C. ≈130d et. Seq., 45 C.F.R. Parts 160 & 164*
*** 42 U.S.C. ≈290dd-2, 42 C.F.R. Part 2*

The Centers must obtain your written consent before it can disclose information about you for payment purposes. For example, the Centers must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the Centers can share information for treatment purposes or for healthcare operations. However, federal law permits The Centers to disclose information in the following circumstances without your written permission:

- To program staff for the purposes of providing treatment and maintaining the clinical record;
- Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, record storage services, billing services.);
- For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and /or Federal government);
- To report a crime committed on the Centers premises or against the Centers personnel;
- To appropriate authorities to report suspected child abuse or neglect;
- To report certain infectious illnesses as required by state law;
- As allowed by a court order.

Before the Centers can use or disclose any information about your health in a manner, which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. You may revoke any such written consent in writing. (NOTE: Revoking consent to disclose information to court may violate an agreement you have with the organization. Such violation may result in legal consequences for you.)

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our system except when the release is required or authorized by law or regulation.

ACKNOWLEDGEMENT OF RECIEPT OF THIS NOTICE

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION

"Protected health information" is individually identifiable health information. This information includes demographics, for example, age, address, e-mail address, and relates to your past, present, or future physical or mental health or condition and related health care services. PMRC is required by law to do the following:

- Make sure that your protected health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Follow the terms of the notice currently in effect.
- Communicate any changes in the notice you.

We reserve the right to change this notice. Its effective date is at the top of the first

page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures

By law, we must disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a health care contractor who provides care to you. We may disclose you protected health information form time-to-time to another physician, or health care provider who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities PMRC might undertake to determine eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

We will share your protected health care information with third-party "business associates" who perform various activities (for example, billing and transcription services). The business associates will also be required to protect your health information.

Required by Law

We may use or disclose your protected health information if law or regulation requires the use or disclosure.

Public Health

We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. The disclosure may be necessary to do the following:

- Prevent or control disease, injury, or disability.
- Report child abuse or neglect.
- Report reactions to medications or problems with products.
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notify the appropriate government authority if we believe a patient has be the victim of abuse, neglect, or domestic violence.

Law Enforcement

We may disclose protected health information for law enforcement purposes, including the following:

- Responses to legal proceedings
- Information requests for identification and location
- Circumstances pertaining to victims of a crime
- Deaths suspected from criminal conduct
- Crimes occurring on a PMRC site
- Medical emergencies believed to result from criminal conduct

Workers' Compensation

We may disclose your protected health information to comply with workers'

compensation laws and other similar legally established programs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMITION

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. The following are examples in which your agreement or objection is required.

Rights to Request Restrictions

You may request us not to use or disclose any part of your protected health information for treatment, payment, or health care operations. All requests must be made in writing. In your request you must tell us (1) what information you want restricted; (2) whether you want to restrict our use, disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date.

If PMRC believes that the restriction is not in the best interest of either party, or PMRC cannot reasonably accommodate the request, PMRC is not required to agree. If the restriction is mutually agreed upon, we will not use or disclose you protected health information in violation of that restriction, at any time, in writing.

Rights to an Accounting of Disclosure

You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to family members or friends involved in your care, or limitations as described earlier in this notice.

CONTACT INFORMATION

Write to:
Attn: Joe M. Hernandez
San Antonio Sleep Centers
4242 Medical Drive, Suite 7300
San Antonio, Texas 78229
(210) 614 – 7474 / (210) 614-7475 Fax

This notice is effective in its entirety as of April 14, 2003. I have read this document and understand the contents and my rights as stated above.

FEDERAL PRIVACY LAWS

This PMRC Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and accountability Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, The Privacy Act and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken

into consideration in developing our policies and this notice of how we will use and disclose your protected health information.