Central Washington Sleep Diagnostic Center, PLLC

520 West Indian Avenue
Brewster, WA 98812
Phone: (509) 689-0100
Fax: (509) 689-0596

603 N. Mission Street
Wenatchee, WA 98801
Phone: (509) 663-1578
Fax: (509) 663-0174

2323 W. Broadway, Suite 4
Moses Lake, WA 98837
Phone: (509) 663-1578
Fax: (509) 663-0174

6614 E. Main Avenue
Spokane, WA 99202
Phone: (509) 663-1578
Fax: (509) 663-0174

www.cwsleepcenter.com

You have been scheduled for a consultation with
Dr. Eric Haeger / Molly Downey PA-C / Jonathan Henke PA / Andrew Swartsel, PA-C
for sleep related issues.

Your appointment is: _____

LOCATION OF APPOINTMENT:

Brewster
520 West Indian Avenue
Brewster, WA 98812
Phone: (509) 689-0100
Fax: (509) 689-0596

Wenatchee
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Spokane
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Spokane, WA 99202
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OUTREACH CLINIC LOCATIONS:

Lake Chelan Hospital
503 E. Highland Ave, 3rd Floor
Chelan, WA 98816

Mid-Valley Clinic
529 Jasmine Street
Omak, WA 98841

Coulee Family Medicine
Coulee Medical Arts Clinic
411 Fortuyn Rd
Grand Coulee, WA 99133

Richland
Columbia Parks Pro Ctr
925 Stevens Drive, Suite 3D
Richland, WA 99352

Please fill out the attached packet of paperwork and bring it with you along with your insurance card and co-pay to your above scheduled appointment. This will ensure your appointment runs efficiently.

If you have any questions, please call the Sleep Center at (509) 663-1578 for Chelan Wenatchee/Moses Lake/Spokane/Richland or (509) 689-0100 for Brewster/Omak/Grand Coulee. We look forward to serving you.

Sleep Well. Love Life.

Thank you,

Central Washington Sleep Diagnostic Center Staff

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Brewster, WA 98812
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Welcome to our practice and thank you for choosing us to serve your health care needs.

Late Arrival Policy

Effective December 1, 2016, we will implement a "late arrival" policy which will affect all patients who do not keep their scheduled appointment or are more than 20 minutes late for their office visit.

In an effort to be fair to all our patients, (including those who are on time), if you are late for an appointment, we will try to accommodate you at the earliest possible time. Unfortunately, patients who arrived on time for their appointment will be seen first.

This may result in long wait times; most patient's find it preferable to reschedule the appointment rather than wait. Please be sure to let the nurse know if you are having an emergency so we can handle the problem immediately.

New patients who are more than 15 minutes late will not be seen and must be rescheduled to allow enough time for a full history and physical exam.

In order to maintain clinic efficiency please call our office at 509-689-0100 and speak with another staff member to reschedule your appointment for another day.

Thank you,

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CANCELLATION / NO-SHOW POLICY

$25 CHARGE FOR OFFICE VISIT NO-SHOW
$50 CHARGE FOR SLEEP STUDY NO-SHOW

You will be considered a no-show if you miss an appointment or sleep study and do not notify us at least 24 hours in advance.

Payment of the missed appointment fee must be made in cash, valid credit card, or verified check BEFORE further appointments are allowed to be scheduled. This charge is NOT payable by your insurance company.

"CMS (Center for Medicare Services) has now clarified that they will allow physicians and other providers to charge Medicare beneficiaries for missing appointments, provided that they do not discriminate against Medicare patients and also charge non-Medicare patients for missed appointments."

Our follow-up protocols are based on years of experience and provide you with the highest standard of care. Keeping follow-up appointments are an important part of the legal contract that forms between you and the sleep clinic when you agree to become a patient.

If there is a 20% no-show rate, we must "overbook" by 20%. If everyone shows, the lobby becomes crowded and waiting times and stress levels increase. Please comply with our appointment policy so that we can stay on schedule.

Our clinic will make every effort to remind you of your appointment. Please update your home, work, and cellular telephone numbers, and your e-mail address each time you visit.

You can call us to cancel and re-schedule during regular business hours, Monday-Thursday from 8am-5pm and Friday from 8am-3pm.

Central Washington Sleep Diagnostic Center, PLLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name _____ SS # _____
Mailing Address _____ DOB _____
Physical Address _____ Sex □ M □ F
City _____ Zip _____ Phone # _____
Employer _____ Cell Phone # _____
Occupation _____ Email _____
Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated
Ethnicity(required) □ Not Hispanic or Latino □ Hispanic or Latino □ Unknown
Race(required) □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other

BILLING INFORMATION

Responsible Party:
Relationship to Patient: □ Self □ Spouse □ Mother □ Father □ Other _____
Full Name _____ SS # _____
Mailing Address _____ DOB _____
City _____ Zip _____ Sex □ M □ F
Employer _____ Phone # _____
Occupation _____ Cell Phone # _____

Emergency Contact _____ Phone # _____
How did you hear about us? □ doctor □ friend □ internet □ billboard □ other _____
Preferred method of contact □ phone □ email □ letter □ patient portal □ other

INSURANCE INFORMATION

Primary Insurance Company _____
Subscriber Name _____ Date of Birth _____
ID # _____ Group # _____

□ N/A
Secondary Insurance Company _____
Subscriber Name _____ Date of Birth _____
ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I hereby authorize Central Washington Sleep Diagnostic Center, PLLC and/or its agents to examine and perform necessary testing to me. I authorize the assignment of insurance benefits, if any, for services rendered to be paid directly to Central Washington Sleep Diagnostic Center, PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I acknowledge that I have received and read the Notice of Privacy Practices and Patients' Bill of Rights.

I have read and agree to abide by the Patient Financial Policy.

Patient/Guardian Signature _____ Date _____

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Authorization for Release of Information

Patient Name _____ Date of Birth _____

I. AUTHORIZATION SECTION **Please disclose the following information:**

_____ The most recent 2 years of pertinent information – chart notes, labs, x-rays, and special tests.

_____ All medical records

_____ Specific information – Please list _____

The following items must be initialed to be EXCLUDED from use and/or disclosure of other health information:

_____ HIV/AIDS _____ Mental health _____ Genetic testing information and/or records

_____ Drug/alcohol abuse _____ Reproductive care (minors only) _____ Sexually transmitted diseases

MINORS - a minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted disease (age 14 and older); (2) alcohol and/or drug abuse (age 13 and older); and (3) mental health conditions (age 13 and older).

Health care information to be released FROM:

Name and/or organization _____

Address _____ City _____ State _____ Zip _____

Phone number _____ FAX Number _____

Health care information to be released TO:

Name and/or organization _____

Address _____ City _____ State _____ Zip _____

Phone number _____ FAX Number _____

II. EXPIRATION

This authorization ends: Date _____ or Event _____

III. SIGNATURE Patient _____ Date _____

INCOMPETENT PATIENT - The following individuals may authorize in order of priority: guardian (with valid papers), durable power of attorney for health care decisions, spouse, adult children, parents, adult brothers or sisters.
PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS – I hereby declare under penalty of perjury that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

Parent/Legal Guardian Signature _____ Date _____

Relationship _____

IV. REVOCATION

You may revoke this authorization at any time by signing and dating this section or by writing a letter to Central WA Sleep Diagnostic Center. **Revocation does not affect any actions already taken by Central WA Sleep Diagnostic Center based on this authorization.**

I hereby revoke this authorization.

Signature _____ Date _____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

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EPWORTH SLEEPINESS SCALE

Patient Name _____ Date _____

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent weeks. 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 = no chance of dozing
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 (e.g. theater or a 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Site: _____ ID #: _____
Technician: _____ Date of Data Entry: _____
Trial: _____

Name: _____ Date: _____

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put a (_) in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?		❒	❒	❒	❒
2. Do you generally have difficulty remembering things, because you are sleepy or tired?		❒	❒	❒	❒
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	❒	❒	❒	❒	❒
4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	❒	❒	❒	❒	❒

Site: _____ ID #: _____
Technician: _____ Date of Data Entry: _____
Trial: _____

Name: _____ Date: _____

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, moderate difficulty	(1) Yes, extreme difficulty
5. Do you have difficulty visiting with your family or friends in <u>their</u> home because you become sleepy or tired?	❒	❒	❒	❒	❒
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	❒	❒	❒	❒	
7. Do you have difficulty watching a movie or videotape because you become sleepy or tired?	❒	❒	❒	❒	❒
8. Do you have difficulty being as active as you want to be in the <u>evening</u> because you are sleepy or tired?		❒	❒	❒	❒
9. Do you have difficulty being as active as you want to be in the <u>morning</u> because you are sleepy or tired?		❒	❒	❒	❒

	(0) I don't engage in sexual activity for other reasons	(4) No	(3) Yes, a little	(2) Yes, moderately	(1) Yes, extremely
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?	❒	❒	❒	❒	❒

Thank you for completing this questionnaire.

Review of Systems

(Please check all that apply.)

Patient: _____ Date of Birth: _____

Constitutional

- □ fatigue, loss of energy
- □ night sweats
- □ weight loss
- □ weight gain
- □ waking up early
- □ difficulty falling asleep

Eyes

- □ blurry vision
- □ double vision
- □ eye pain
- □ redness
- □ wears contacts
- □ wears glasses

ENT (Ears, Nose, Mouth, Throat)

Ears

- □ hearing loss
- □ ringing in ears

Nose

- □ stuffiness
- □ runny nose
- □ sneezing
- □ post-nasal drip
- □ nosebleeds
- □ sinus pain/pressure

Mouth/Throat

- □ toothache
- □ gum pain/bleeding
- □ dry mouth
- □ sore throat
- □ hoarseness
- □ trouble swallowing
- □ dentures

Neck

- □ neck pain
- □ neck stiffness
- □ lumps
- □ swollen glands

Cardiovascular

- □ chest pain
- □ chest tightness
- □ palpitations
- □ trouble breathing lying down
- □ fainting
- □ loss of consciousness
- □ heart murmur
- □ high blood pressure
- □ swelling/edema

Respiratory

- □ productive cough
- □ nonproductive cough
- □ sputum
- □ infections
- □ coughing up blood
- □ shortness of breath
- □ wheezing
- □ painful breathing
- □ exercise intolerance

GI

- □ decreased appetite
- □ increased appetite
- □ heartburn

GU

- □ urinary incontinence
- □ increased urination at night
- □ erectile dysfunction

Musculoskeletal

- □ muscle pain
- □ muscle weakness
- □ back pain

Neurological

- □ headache
- □ morning headache
- □ tingling arms/legs
- □ weakness
- □ dizziness
- □ loss of balance
- □ speech disturbance
- □ seizures
- □ lightheadedness
- □ slow thinking
- □ slow moving
- □ tremor
- □ head injury

Psychiatric

- □ depression
- □ anxiety
- □ nervousness
- □ stress
- □ loss of interest
- □ trouble concentrating
- □ thoughts of suicide
- □ memory loss
- □ feelings of guilt
- □ paranoia
- □ hallucinations
- □ decreased work/school performance
- □ see people/things others do not see

Endocrine

- □ goiter
- □ heat/cold intolerance
- □ diabetes
- □ thyroid problems

Hematologic/Lymphatic

- □ anemia
- □ transfusions

Allergy/Immunologic

- □ seasonal allergies