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
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Fax: (509) 689-0596

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

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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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 _____

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PEDIATRIC SLEEP QUESTIONNAIRE

Child's Information	
Child's Name:	Child's Gender: □ Male □ Female Your provider
Child's Birthdate:	Child's Age:
Parent Name(s):	Today's Date:
Child's Primary Provider:	Child's Referring Provider:

It is important for you to be as accurate and thorough as possible in answering the following questions. The purpose of this questionnaire is to get a complete picture of your child's background and the nature of your child's present problem. This will assist the physician to create an individualized treatment plan.

Child's Problem or Area of Concern
Describe your major concern(s) about your child's sleep?
What treatment has your child received in the past?

Child's Sleep History

General Sleep

Does the child have a regular bedtime routine? □ Yes □ No
Does the child have his / her own bed? □ Yes □ No
Does the child have his / her own bedroom? □ Yes □ No
Is a parent / guardian present when the child falls asleep? □ Yes □ No

Child usually falls asleep in:	Child sleeps most of the night in:	Child usually wakes in the am in:
□ own room in own bed (alone)	□ own room in own bed (alone)	□ own room in own bed (alone)
□ parent's room in own bed	□ parent's room in own bed	□ parent's room in own bed
□ parent's room in parent's bed	□ parent's room in parent's bed	□ parent's room in parent's bed
□ sibling's room in own bed	□ sibling's room in own bed	□ sibling's room in own bed
□ sibling's room in sibling's bed	□ sibling's room in sibling's bed	□ sibling's room in sibling's bed

Child is usually put in bed by: □ Mother □ Father □ Both Parents □ Sibling □ Self □ Other

Write the amount of time the child spends in his / her bedroom before going to sleep: _____ minutes

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Child's Sleep History (continued)

Child resists going to bed?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
Child has difficulty falling asleep?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
Child awakens during the night?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
After a night-time awakening, child has difficulty going back to sleep?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No

Weekday Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekdays (daytime & nighttime) _____ hours _____ minutes

Child's usual bedtime on weekday nights: _____:_____

Child's usual wake time on weekday mornings: _____:_____

Weekend Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekends (daytime & nighttime) _____ hours _____ minutes

Child's usual bedtime on weekend nights: _____:_____

Child's usual wake time on weekend mornings: _____:_____

Nap Schedule

How many naps does your child take during the day (circle one): 1 2 3 4 5 6 7 8 9 10

What is your child's usual nap time(s): _____:_____ am / pm TO _____:_____ am / pm

_____:_____ am / pm TO _____:_____ am / pm

_____:_____ am / pm TO _____:_____ am / pm

Child's Daytime Symptoms

Please circle the appropriate number:

1 = Never
2 = less than 1 night / day per week
3 = 1 - 2 nights / days per week
4 = 3 - 5 nights / days per week
5 = 6 - 7 nights / days per week
6 = Unknown

Has trouble getting up in the morning	1	2	3	4	5	6
Falls asleep at school	1	2	3	4	5	6
Naps after school	1	2	3	4	5	6
Has daytime sleepiness	1	2	3	4	5	6
Feels weak or loses muscle control with strong emotions	1	2	3	4	5	6
Reports unable to move when falling asleep or awakening	1	2	3	4	5	6
Sees frightening images when falling asleep or awakening	1	2	3	4	5	6

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Child's Sleep Symptoms						
Please circle the appropriate number: **1** = Never **4** = 3 - 5 nights per week **2** = less than 1 night per week **5** = 6 - 7 nights per week **3** = 1 - 2 nights per week **6** = Unknown						
Stops breathing during sleep	1	2	3	4	5	6
Has difficulty breathing during sleep	1	2	3	4	5	6
Snores	1	2	3	4	5	6
Restless sleep	1	2	3	4	5	6
Sweating when sleeping	1	2	3	4	5	6
Daytime sleepiness	1	2	3	4	5	6
Poor appetite	1	2	3	4	5	6
Has nightmares	1	2	3	4	5	6
Sleep walks	1	2	3	4	5	6
Sleep talks	1	2	3	4	5	6
Screams in his / her sleep	1	2	3	4	5	6
Kicks legs in sleep	1	2	3	4	5	6
Wakes up during the night	1	2	3	4	5	6
Gets out of bed at night	1	2	3	4	5	6
Trouble staying in his / her own bed	1	2	3	4	5	6
Resists going to bed at bedtime	1	2	3	4	5	6
Grinds his / her teeth	1	2	3	4	5	6
Uncomfortable feeling in legs - creepy-crawly feeling	1	2	3	4	5	6
Wets bed	1	2	3	4	5	6

Child's Past Psychiatric / Psychological History			
Autism	□ No	□ Yes	Age of diagnosis:
Developmental delay	□ No	□ Yes	Age of diagnosis:
Hyperactivity / ADHD	□ No	□ Yes	Age of diagnosis:
Anxiety / panic attacks	□ No	□ Yes	Age of diagnosis:
Obsessive compulsive disorder	□ No	□ Yes	Age of diagnosis:
Depression	□ No	□ Yes	Age of diagnosis:
Suicide	□ No	□ Yes	Age of diagnosis:
Learning disability	□ No	□ Yes	Age of diagnosis:
Drug use / abuse	□ No	□ Yes	Age of diagnosis:
Behavioral disorder	□ No	□ Yes	Age of diagnosis:

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Psychiatric hospital admission	□ No	□ Yes	Age of admission:

Child's Past Medical History			
Frequent nasal congestion	□ No	□ Yes	Age of diagnosis:
Trouble breathing through nose	□ No	□ Yes	Age of diagnosis:
Sinus problems	□ No	□ Yes	Age of diagnosis:
Chronic bronchitis or cough	□ No	□ Yes	Age of diagnosis:
Allergies	□ No	□ Yes	Age of diagnosis:
Allergies to medications	□ No	□ Yes	Which one(s):
Asthma	□ No	□ Yes	Age of diagnosis:
Frequent colds or flu	□ No	□ Yes	Age of diagnosis:
Frequent ear infections	□ No	□ Yes	Age of diagnosis:
Frequent strep throat infections	□ No	□ Yes	Age of diagnosis:
Difficulty swallowing	□ No	□ Yes	Age of diagnosis:
Acid reflux (GERD)	□ No	□ Yes	Age of diagnosis:
Poor or delayed growth	□ No	□ Yes	Age of diagnosis:
Excessive weight	□ No	□ Yes	Age of diagnosis:
Hearing problems	□ No	□ Yes	Age of diagnosis:
Speech problems	□ No	□ Yes	Age of diagnosis:
Vision problems	□ No	□ Yes	Age of diagnosis:
Seizures / epilepsy	□ No	□ Yes	Age of diagnosis:
Morning headaches	□ No	□ Yes	Age of diagnosis:
Cerebral palsy	□ No	□ Yes	Age of diagnosis:
Heart disease	□ No	□ Yes	Age of diagnosis:
High blood pressure	□ No	□ Yes	Age of diagnosis:
Sickle cell disease	□ No	□ Yes	Age of diagnosis:
Genetic disease	□ No	□ Yes	Age of diagnosis:
Chromosome problem (ex. Down's)	□ No	□ Yes	Age of diagnosis:
Skeleton problem (ex. Dwarfism)	□ No	□ Yes	Age of diagnosis:
Craniofacial disorder (ex. Pierre-Robin)	□ No	□ Yes	Age of diagnosis:
Thyroid problems	□ No	□ Yes	Age of diagnosis:
Eczema (ex. itchy skin)	□ No	□ Yes	Age of diagnosis:
Pain	□ No	□ Yes	Age of diagnosis:
Head / brain injury	□ No	□ Yes	Age of diagnosis:
Meningitis	□ No	□ Yes	Age of diagnosis:
Other	□ No	□ Yes	Age of diagnosis:

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Child's Current Medications

Please list any medications the child is currently taking:

Medication: Dose: How Often:

_____

_____

_____

_____

Child's Long Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

1 _____

2 _____

3 _____

Child's Surgeries / Hospitalizations

Has the child had his / her tonsils removed? □ No □ Yes Age of surgery: _____

Has the child had his / her adenoids removed? □ No □ Yes Age of surgery: _____

Has the child ever had ear tubes? □ No □ Yes Age of surgery: _____

Please list any additional hospitalizations or surgeries:

1 _____ Age: _____

2 _____ Age: _____

3 _____ Age: _____

Child's Health Habits

Does the child drink caffeinated beverages? □ No □ Yes Amount per day: _____

(ex. Coke, Pepsi, Mountain Dew, Orange Soda, Tea, Coffee, Energy Drinks) Time of last drink: _____

Child's School Performance (if school age)

Child's grade: _____ Name of school: _____

Has child ever repeated a grade: □ No □ Yes

Is child enrolled in any special education classes □ No □ Yes Which one(s): _____

How many school days has child missed this year? _____

How many school days did child miss last year? _____

How many school days has child been late this year? _____

How many school days was child late last year? _____

Child's grades this year? □ Excellent □ Good □ Average □ Poor □ Failing

Child's grades last year? □ Excellent □ Good □ Average □ Poor □ Failing

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Child's Family Information

Pregnancy / Delivery

Pregnancy □ Normal □ Difficult

Delivery □ Term □ Pre-Term □ Post-term

Child's birth weight: _____

Only child? □ Yes □ No If no, circle birth order: 1st 2nd 3rd 4th 5th 6th

Mother	Father
Age: _____	Age: _____
Marital Status: □ Married □ Divorced □ Single □ Widowed □ Separated □ Remarried	Marital Status: □ Married □ Divorced □ Single □ Widowed □ Separated □ Remarried
Education: _____	Education: _____
Work: □ Full-time □ Part-time □ Unemployed	Work: □ Full-time □ Part-time □ Unemployed
Occupation: _____	Occupation: _____

Persons Living in Home

Name: Relationship: Age:

_____

_____

_____

_____

_____

_____

Family Sleep History

Does anyone in the child's family have a sleep disorder? □ No □ Yes

If yes, mark the disorders and relationship.

Insomnia	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Snoring	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Sleep apnea	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Restless legs syndrome	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Periodic limb movement d/o	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Sleep walking	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Sleep terrors	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Sleep talking	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Narcolepsy	□ Mother	□ Father	□ Brother / Sister	□ Grandparent
Other: _____	□ Mother	□ Father	□ Brother / Sister	□ Grandparent

Is there any other information you think would be helpful for the physician to know?

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