True North Neurology

1010 Route 112, 3rd Fl., Suite 300 Port Jeff. Sta NY 11776
5 Medical Drive, Port Jeff, Stat., NY 11776
6080 Jericho Tpke. Suite 100, Commack NY 11725
1500 William Floyd Pkwy, Suite 303, Shirley, NY 11967

SLEEP PATIENT INTAKE FORM

PATIENT INFORMATION Date _____

Name _____ DOB_____ SEX F / M

Address _____Apt_____

City_____ State _____ Zip _____

Primary Phone _____ Other _____ Marital Status: C S M D WO

E-mail: _____ SS#_____

INSURANCE INFORMATION:

Primary _____ Policy Holder _____ DOB_____

Relation to Patient _____ ID # _____ Group # _____

Secondary _____ Policy Holder _____ DOB_____

Relation to Patient _____ ID # _____ Group # _____

Preferred Language _____ Ethnicity & Race _____

Employer _____ Occupation_____

Address _____ City _____ State_____Zip_____

Emergency Contact

_____Relation_____Phone_____

Referring Physician

_____ Phone_____

Primary Doctor

_____ Phone _____

How did you hear about our office?

_____

Reason for this Visit:

_____

Medications

HEALTH QUESTIONNAIRE

Please list all CURRENT medical problems and doctors you are seeing:

Weight: _____ Height: _____ Level of education: _____

Do you have any Allergies: Y N Allergies to: _____?

What type of reaction do you get _____?

Please list all PAST medical problems, operations, hospital admissions: _____

_____

_____

Amounts per day: Alcohol _____ Coffee _____ Tea _____ Tonic/soda _____ Water_____
If you smoke, how much? _____ Recreational drugs: _____ yes _____ no
Present work status: _____ Do you like your job? _____ yes _____ no _____ not sure

With whom are you living (list relationships and ages): _____
If you have children, please list their ages: _____
Please list hobbies/recreational activities: _____
Do you have pets? _____

Any serious problems at home? _____yes _____ no Describe (if yes): _____

Is there any family history of?
_____ Sleep disorders _____Headaches _____ Mental illness _____ Strokes _____ Cancer
_____ Seizures _____ Alcoholism _____ Obesity _____ Heart Disease _____ Diabetes
_____ Goiter/Thyroid _____ Excessive bleeding _____ Tuberculosis _____ Arthritis
_____ High blood pressure _____ other (Explain) _____
Have you had any of the following problems in the past 6 months (circle all that apply)?

Sleep disorders	sinus problems	daytime sleepiness	teeth grinding
insomnia	bad dreams /snoring	sweating	jaw clenching
restless leg	dental problems	breathing difficulty	heartburn
headaches	nausea/vomiting	stomach pain	constipation
chronic cough	muscle aches	leg/foot cramps	diarrhea
change in smoking/drinking	bleeding/bruising	chest pain	weakness
high blood pressure	palpitations	wheezing	dizziness
joint pain/swelling/redness	ringing in ears	numbness	hoarseness
excessive urination/thirst	bladder problems	irregular periods	PMS
cold hands and feet	poor coordination/balance	depression	change in diet
breast lumps/discharge	symptoms of menopause	sexual dysfunction	irritability
hospitalization/surgery	back pain	neck pain	decline in memory
feeling spacey/brain fog	anxiety/panic attacks	suicidal thoughts	change in skin/hair
change in vision	seizures/shaking	loss of consciousness	fever/chills
change in marital status	change in job/school	weight loss or gain	skin rash
emotional trauma	new illness diagnosed	Deviated septum	Asthma
Parkinson's	Stroke	Other:	

Information Release

I request that payment of authorized insurance benefits be made on my behalf to **True North Neurology**, for any services furnished me by physicians. I authorized any holder of medical information about me to release to the Health Financial administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name:

_____

Patient's Signature: _____ **Date:** _____

Patient Financial Agreement /Guarantee of Payment

Dear Patient

As a service to our patients, our office accepts assignments of most major medical plans. However, in the current managed care environment, reimbursement for certain services has been increasingly difficult to obtain. In addition, most in-office procedures now require pre-certification or referral. In an effort to continue to give our patients excellent, yet affordable care, we ask that you take time to read and sign the following agreement. This will enable us to continue to submit insurance claims on behalf of our patients.

- I understand that I must have a current **Insurance Referral** on file for every office visit and that it is my responsibility to obtain referrals from my PCP, according to the guidelines of my plan. If a referral is not obtained, I understand I will be responsible for the office visit.
- I understand that **Co-Payments** must be paid at the time of service.
- I understand that **I will be Responsible** for all deductibles, co-insurances and unpaid "allowable amounts."
- I understand that the doctor has agreed to accept assignment from my insurance carrier for services rendered in the office if participating.
- I understand that it is **my** responsibility to update **my** insurance information on file and give a copy of my insurance card.
- I understand that certain services performed by the doctor may not be covered under my insurance as outlined in policy. **If the insurance denies payment, I will personally and fully be responsible for a payment.**
- I understand True North Neurology invokes a strict fifteen (15) minute late policy and my appointment will be forfeited if not followed.

***24 Hour Cancellation Policy**

I understand I must give the office **24 hours' advance notice** in order to cancel my appointment. If an appointment is not cancelled with 24-hour notice, I will incur a **$50 fee** for all missed physician appointments, $**100 fee** for any daytime procedure appointments and **$200 fee** for any 4PM and later procedure.

Patient Name: _____

Patient's Signature: _____ **Date:** _____

NOTICE OF PATIENT CONFIDENTIALITY POLICY

Policy:

True North Neurology, here, in after referred to as True North Neurology is firmly committed to preserving the confidentiality of all patient encounter within the limitations of the law of the State of New York.

Practices:

Patients who come to True North Neurology may anticipate that healthcare providers and other office employees will treat patient information as confidential and will act in such a manner to protect the privacy and confidentiality of both clinical and personal information.

Patients must understand, however, that there are circumstances in which certain aspects of their healthcare services can and will be available to outside parties. These parties may include but may not be limited to health insurance companies and other payment guarantors such as parents, legal guardians, third party payers and employers. This loss of complete confidentiality occurs because of the need to report healthcare services to insurance companies and/or situations as listed below in confidentiality limitations. Information that may be made available can include diagnostic testing information, therapeutic procedures and prescription drug information.

Any concerns about confidentiality should be addressed to the provider or nurse at the time of services.

Limitations of Confidentiality:

Confidentiality is limited in the following situations:

1. A court order or subpoenas for medical records is issued.
2. A patient is determined to be at risk of harm to self or others.
3. The patient makes or authorizes a claim under a health insurance or other health benefit plan or otherwise designates someone else as responsible for payment.
4. The law requires reporting of information (e.g., communicable diseases, injury by violent means, workers compensation injury)
5. The patient is a minor.

In any of these situations, information in medical records may be released, without the consent of the patient to necessary parties, which may include but not limited to, a court of law, parents, health insurance companies and other payment guarantor such as parents, legal guardians, third party payers, law enforcement or employers.

Persons under the age 18 (minor) generally must have consent of an adult parent to obtain medical treatment. Parents of minors who obtain medical treatment will likewise normally be entitled to information about the treatment. Exceptions are recognized for the provision of contraceptives, drug abuse treatment, prenatal care and emergency care.

Your signature below indicates that you have read and understand True North Neurology's confidentiality policy.

Please list anyone we can discuss your medical information with.

NAME	**RELATIONSHIP TO PATIENT**	**PHONE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

This authorization shall be in effect until revoked by the patient.

SIGNATURE: _____ **DATE:** _____

TRUE NORTH NEUROLOGY
Tel: 631-364-9119 FAX: 833-799-0474

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Address: _____

Phone:

Requested Information:

- ☐ **All medical Records**
- ☐ **Radiology (X-Ray, MRI, etc.)**
- ☐ **Laboratory Testing**
- ☐ **Consults**
- ☐ **Dates of Treatment: From** _____ **To** _____
- ☐ **Diagnostic Studies**
- ☐ **Progress Notes**
- ☐ **Other**_____

I understand that my medical record may include a wide variety of inpatient and outpatient information on diagnosis, treatment and procedures including psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS) and (HIV) status.

For the purpose of: **CONTINUITY OF CARE**

RELEASE FROM: _____

TEL: _____ **FAX:** _____

ADDRESS: _____

_____

RELEASE TO: TRUE NORTH NEUROLOGY

TEL: 631-364-9119 FAX: 855-644-2983

I understand that I have a right to revoke this authorization at any time. I understand that if revoke this authorization, I must do so in writing and present my written revocation to a staff member of True North Neurology I understand that the revocation will not apply to information that has already been released by the authorization. This authorization will be expired 12 months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the office manager at the practice. New York State Law Section 17 and 18 of the Public Health Law, Chapter 165, section 48 & 49, states $0.75 per page plus postage for your medical record is legal charge that is permitted.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Print Name of Patient or Guardian **If not signed by patient, please indicate**

Sleep History Questionnaire

Name: _____ I began having sleep issues at the age of: _____

History- Nighttime

I need a Sleep Study due to:

○ Excessive fatigue ○ Snoring ○ Stop breathing during sleep ○ Insomnia ○ Leg Jerks ○ Other

○ I'm a caretaker ○ Pain ○ Always hot or cold ○ hungry/ thirsty ○ partners movements.

My life has become disrupted by:

○ Waking up tired ○ Lack of Focus due to sleepiness ○ Falling asleep during the day ○ Worrying about my sleep habit ○ Other

On Workdays: ○ I go to sleep at: _____ ○ I wake up at: _____ ○ I get out of bed at: _____

On Days Off: ○ I go to sleep at: _____ ○ I wake up at: _____ ○ I get out of bed at: _____

It takes me over 30 minutes to fall asleep. ○ YES ○ NO

It takes more than 60 minutes to fall asleep. ○ YES ○ NO

Do you wake during the night: ○ YES ○ NO How many times_____ . Is it hard to go back to sleep_____

Check all that apply to Nighttime Sleep:

Bed-Wetting? No _____Yes _____How often_____

Vivid Dreams? No _____Yes _____How often_____

Teeth grinding No _____Yes _____How often_____

Sleep talking No _____Yes _____How often_____

Need to walk due to pain: No _____Yes _____How often_____

Sleep Walking: No _____Yes _____How often_____

Heartburn/ Nausea No _____Yes _____How often_____

Congestion No _____Yes _____How often_____

Thoughts racing through your head No _____ Yes _____ How often_____

Unable to move when falling asleep No _____ Yes _____ How often_____

Unable to move when walking No _____ Yes _____ How often_____

Wake gasping or choking No _____ Yes _____ How often_____

Do you wake confused or violent No _____ Yes _____ How often_____

Do you act out dreams No _____ Yes _____ How often_____

Do you go to the bathroom often No _____ Yes _____ How often_____

Do you wake depressed or worried No _____ Yes _____ How often_____

Hallucinations /dream like images No _____ Yes _____ How often_____

"Blackouts" Unable to recall tasks you've done No _____ Yes _____ How often_____

Sudden muscular movements No _____ Yes _____ How often_____

Unintentionally falling asleep No _____ Yes _____ How often_____

Have you ever had a PSG (Sleep Study) No _____ Yes _____ Date _____

Have you ever had a CPAP No _____ Yes _____ Date _____

Have you ever had a BiPAP No _____ Yes _____ Date _____

Have you ever had an EEG No _____ Yes _____ Date _____

Have you ever been seen by a psychiatrist? No _____ Yes _____ Presently _____

How many caffeinated items (chocolate, coffee, tea, soda, etc.) do you have a day? _____ How many hours before bed _____

How many naps (if any) do you take during the day _____ Do you routinely exercise _____ How Often _____

Do you use any stimulants to "pep you up" during day like? If yes please give name of stimulant _____ Mg._____

Have you ever had an accident or near accident due to sleepiness? No _____ Yes _____ Date_____

Explain_____

This part is to be answered by someone who has observed you sleeping:

Relation to patient_____ *Please circle choices -

Have you personally experienced seeing patient?

Stop Breathing	Choking	Snoring	Grinding Teeth	Sleepwalk	Body or Limb Jerk
Talking or Moaning	fall asleep within five minutes		Acting out dreams	Other	

Fall asleep during the day or evening activities causing a situation the can bring harm to patient or others?

If you have circled any item above please take a moment and explain.

_____

_____

_____

_____

_____

_____

- Notes: