Vanguard Sleep Disorders Center LLC.

Welcome to Vanguard Sleep Disorders Center LLC.

We would like to thank you for choosing us as your sleep health care provider.

Your health is a responsibility we take very seriously. Vanguard Sleep Disorders Center LLC. specializes in providing diagnosis, treatment, and medical management for individuals with sleep / wake disorders such as sleep apnea, insomnia, narcolepsy, and others.

Enclosed are several forms and questionnaires. It is important that you complete each of the attached forms and return to us *prior to* your first appointment. Your signature on these forms gives us permission to provide treatment, to bill your insurance for services and to coordinate care with your primary care physician. They also give us the information needed to document your symptoms and medical history.

Please bring the following with you when you come for your appointment:

- **Your current health insurance card(s)**
- **Your valid driver's license or other state issued photo identification**
- **Utility bill or other correspondence showing your current residential address if your photo ID does not show your current address**

Each form must be initialed and / or signed where needed in order for services to be provided.

If you are unable to keep your appointment, please call and let us know. We will be happy to re-schedule you for a more convenient time. If you do not keep your appointment and do not call to re-schedule or cancel at least **24 hours** prior to your scheduled appointment, a no show/reschedule fee will be charged and billed to you.

Vanguard Sleep Disorders Center LLC
17 B Marshellen Drive
Beaufort SC 29902
Bellevue Business Park-
Across the street from Subway
(843) 962.0714 Fax (843) 941.3720

All paper work must be turned in to our office 24 hours prior to your appointment.

Please Contact our office during business hours for directions to our office. Our telephones are not answered after hours.

Our Business office hours are Monday thru Wednesday 9am to 5pm
Thursday 9am to 12pm and Closed Fridays
The business office closed Saturday and Sunday

Vanguard Sleep Disorders Center LLC.

PATIENT INFORMATION

Name	SS #	Driver's License #
Date of Birth	Age	E-mail Address
Address		
City	State	Zip Code
Home Phone	Cell Phone	Business Phone

Marital Status	❑ Single	❑ Married	❑ Divorced	❑ Widowed

Employer
Position/Job Title

Name of Spouse	Date of Birth
Employed By	SS #
Referring Physician	Primary Care Physician
Insurance Company	Policy #
Medicare #	Medicaid #
Secondary Insurance Company	Policy #
Third Policy. Insurance Company	Policy #

Person responsible for this account:

Name	Address	Relationship to Patient

Name, address, and phone of nearest relative not living at your address:

Name	Address	Phone

I authorize Vanguard Sleep Disorders Center LLC. to release to my insurance company any information required for the processing of claims for services provided. I also assign any insurance benefits to Vanguard Sleep Disorders Center LLC. for any and all charges met by the insurance company. **I understand that I remain responsible to Vanguard Sleep Disorders Center LLC. for any and all charges not met by the insurance company**.

I, the undersigned, hereby agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of the collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions.

I understand that if my office visit requires that I be seen by the nurse practitioner and/or the respiratory therapist that I will be billed for those services accordingly.

I understand that I may be billed a separate fee from the facility for seeing the Physician or for physician services such as sleep study reading fees.

Signature: ____ Date: _______________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical information about me to release such information to Vanguard Sleep Disorders Center LLC. as it applies to my care and treatment rendered by Vanguard Sleep Disorders Center LLC.

Print Name:_____________________________ Signature: ____ Date: ______________

Vanguard Sleep Disorders Center LLC.

SLEEP HEALTH QUESTIONNAIRE

NAME: ____ AGE: ________ DOB: __________________

Height: ________ Weight: ________ Neck Size: ________ BMI (Body Mass Index): __________

Describe your main problem(s), in your own words, including when this began:

How often does this problem occur? ❑ Almost every night ❑ 3-5 nights a week ❑ 1-2 nights a week ❑ Other _______

How long has this problem bothered you? ❑ Longer than 2 years ❑ 1-2 years ❑ Less than 1 year ❑ 1-3 months

Describe your sleep problem (check all of the following that apply):

❑ Difficulty falling asleep ❑ Waking up during the night ❑ Waking up early in morning ❑ Difficulty waking up
❑ Excessive daytime sleepiness ❑ Fallen asleep while driving

Please list any treatments you have received for your sleep problem(s).
____
____
____

MAIN CONCERN

Have you ever been told you stop breathing in your sleep?_______________________ Have you ever had a mental evaluation?_____________

Do you require a care taker at night?___________________________ Do you suffer from PTSD?_________________________

Do you sleep with Oxygen?_________________________ Do you take a sleep aid to help you sleep at night?________________

Are you OCD?__________ Are you ADD?__________ Are you ADHD?__________ Are you ODD? ____________

Do you take antidepressants/SSRI currently? (this can alter EEG on Sleep study so we must know) ____________ If yes what _______________

Do you currently take pain medications? ________________ if yes what ____

WHAT IS YOUR USUAL BED TIME?	HOW LONG DOES IT TAKE YOU TO FALL ASLEEP?
HOW LONG DO YOU SLEEP?	HOW MANY TIMES DO YOU WAKE UP AT NIGHT?
WHAT TIME DO YOU WAKE UP?	WHAT TIME DO YOU GET OUT OF BED?

SLEEP FEATURES

DO YOU SNORE?	____ YES	____ NO	DO YOU KICK YOUR LEGS DURING SLEEP?	____ YES	____ NO
DO YOU TALK, WALK, OR EAT DURING SLEEP?	____ YES	____ NO	DO YOU DREAM?	____ YES	____ NO
DOES YOUR SLEEP PARTNER OBSERVE ANY SLEEP ABNORMALITIES?	____ YES	____ NO	DO YOU ACT OUT YOUR DREAMS?	____ YES	____ NO
DO YOU HAVE ANY DAYTIME SLEEPINESS?	____ YES	____ NO	DO YOU WORK SHIFT WORK?	____ YES	____ NO
HAVE YOU EVER HAD A SLEEP STUDY? IF YES WHAT DATE______________ WHERE AT ________________	____ YES	____ NO	IF YES WHAT SHIFTS?		

IF YOU HAVE EVER HAD A SLEEP STUDY IN THE PAST:
Please provide a copy of previous sleep study results if available.

SLEEP HEALTH QUESTIONNAIRE (continued)

SLEEP FEATURES (continued)

HAVE YOU EVER EXPERIENCED SLEEP PARALYSIS? (INABILITY TO MOVE, SPEAK, OR OPEN ONE'S EYES WHEN FALLING ASLEEP OR WAKING UP) ___YES ____NO	HAVE YOU EVER EXPERIENCED SUDDEN / BREIF LOSS OF MUSCLE STRENGTH OR MUSCLE TONE BROUGHT ON BY STRONG EMOTIONS OR CERTAIN SITUATIONS (CATEPLEXY)? _____YES _____ NO
HAVE YOU EVER EXPERIENCED HYPNAGOGIC/HYPNOPOMPIC HALLUCINATIONS? (**HYPNAGOGIC HALLUCINATIONS** ARE VIVID, DREAM-LIKE EXPERIENCES THAT OCCUR WHEN FALLING ASLEEP; **HYPNOPOMPIC HALLUCINATIONS** ARE SIMILAR BUT OCCUR WHILE WAKING UP? _____ YES ____NO (HYPNAGOGIC) _____ YES ____NO (HYPNOPOMPIC)	Please list any other sleep related symptoms: ____________________ ____________________ ____________________ ____________________ ____________________ ____________________

DO YOU SMOKE? ____ YES ____ NO	DO YOU DRINK ALCOHOL? ____ YES ____ NO
IF YES, HOW MUCH? # ______ PACKS PER DAY	IF YES, WHAT & HOW MUCH?

Do you Drink water?_________________ How many glasses a Day?____________________

What time is your last cup or glass of the day?______________________________

Do you Drink Caffeine? ___________ What kind(ex. Soda, coffee)?_________________ How many glasses a day?________________

REVIEW OF ILLNESSES

(Check all that apply)

ILLNESS	YES	NO	ILLNESS	YES	NO
HEADACHES			DIABETES		
HEAD INJURY			GASTROESOPHAGEAL REFLUX		
COMA			LIVER DISEASE		
VISUAL DISTURBANCE			KIDNEY BLADDER DISEASE		
SEIZURES			ANXIETY, DEPRESSION, OR BIPOLAR		
STROKE When________________			WEIGHT GAIN		
HIGH BLOOD PRESSURE			SINUS DISEASE		
HEART DISEASE			ALLERGIES OR CONGESTION		
LUNG DISEASE			PALATE / SINUS SURGERY		
OTHER			COPD		

Do any other members of your family have sleep problems? ❑ Yes ❑ No If "yes", please describe:

____

____

Does your sleep problem interfere with your work duties/responsibilities? ❑ Yes ❑ No If "yes", please describe:

____

____

Does your sleep problem interfere with your social activities? ❑ Yes ❑ No If "yes", please describe:

____

____

Vanguard Sleep Disorders Center LLC.

SLEEP HEALTH QUESTIONNAIRE (continued)

Does your sleep problem interfere with your sexual activities? ❑ Yes ❑ No If "yes", please describe:

____

____

How many hours of sleep do you usually get per night? Average __________
Does your mind ever race with thoughts when trying to fall a sleep?___________ Are you currently stressed over anything?__________
If yes what?____

If you wake up at night when do you usually awaken? ❑ Soon after falling asleep ❑ Middle of the night ❑ End of the night

Do you Night Eat?_______________ How many times a night do you go to the restroom? ___________ Do you take a Diuretic?__________

What do you usually do when you wake up during the night?

____

____

Do you usually (check all that apply):
❑ sleep with someone else in your bed ❑ sleep with someone else in your room ❑ provide assistance to someone else at night ❑ sleep with the television on ❑Do you ever suffer from Insomnia ❑ Do you have Hypothyroidism ❑ Do you have Hyperthyroidism

Is your sleep often disturbed by (check all that apply):
❑ Heat ❑ Cold ❑ Noise ❑ Light ❑ Bed partner ❑ Not being in your usual bed ❑ Other __________________________

Are your sleep habits on the weekends different from the rest of the week? ❑ No ❑ Yes. If yes, please explain:

____

DURBABLE MEDICAL EQUIPMENT COMPANY I PERSONNALLY CHOOSE TO USE: ____________________________________

❑ **I DO NOT PERSONALLY HAVE A PREFERENCE AND VANGUARD SDC CAN CHOOSE FOR ME**

Signature____

Date:_____________________________

Vanguard Sleep Disorders Center LLC.

Insurance and Financial Policy

__________**(Initial)** Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. Each insurance plan is slightly different in its coverage services. We encourage you to become familiar with your policy exclusions, deductibles, and required co-payments. **You are responsible for your deductible and required co-payments**.
We will bill your insurance company for office visit appointments, follow up visits, DME supplies and sleep studies. However, your co-payment for these visits and supplies is required at the time of service. If you have an unmet deductible your insurance company may apply the allowed office visit charge towards your deductible. We will then bill you for this amount. I understand the above and will pay may balance as it comes due.

Payment Terms

_________**(Initial)** I understand that all bills are due within 30 days after the original statement date. If you are not able to pay the full amount of your bill all at one, you may contact the office to set up a monthly payment plan. If a bill has not been paid on or a payment plan has not been set up within 90 days from the original statement date, we will turn the balance over to a collection company. Checks, cash, and all major credit cards are accepted.

Express Consent for Communication

_________**(Initial)** By signing this form, I expressly consent to and authorize Vanguard Sleep Disorders Center LLC., its affiliates and agents, including but not limited to collections agencies, debt collectors hired by them to communicate with me for any reason related to services provided by Vanguard Sleep Disorders Center LLC including collections of amounts owed for said services.

Freedom of Choice / Disclosure of Ownership

__________**(Initial)** If you are diagnosed with a sleep disorder requiring treatment with a positive airway pressure device (CPAP or BIPAP), for your convenience Vanguard Sleep Disorders Center LLC., can provide the necessary equipment and supplies for you, pending Insurance authorization and contractual agreement. Additionally, Vanguard Sleep Disorders Center LLC. offers on-going education, follow-up, maintenance, supplies and therapy changes & adjustments.

__________**(Initial)** CPAP and BIPAP equipment is also available through other medical equipment suppliers. You may choose to purchase your equipment from another provider. If you do, this will in no way affect or compromise the medical care you will receive from Vanguard Sleep Disorders Center LLC. If you choose another equipment provider we will still follow up with you in our office on regular scheduled visits. Not all suppliers offer these important services, and we want our patients to receive the absolute best medical care possible.

Missed Appointments

_________**(Initial)** We do charge a fee for missed appointments. If you do not keep your scheduled appointment and do not call to cancel or re-schedule your appointment at least 24 hours in advance, a missed appointment charge will be billed to you. Insurance companies generally do not cover these fees.

Financial Responsibility

_________**(Initial)** By signing below I am indicating that I understand the above insurance and financial policy information and agree to be personally responsible for my co-insurance and any portion of my deductible that has not been met at the time of service for physician office visits and or the rental or purchase of medical equipment, accessories and supplies. I also understand and agree that I am fully responsible for any charges that my insurance company does not pay for any reason, that I am solely responsible for my bill. If, for any reason, I default on incurred charges, I will be responsible for any reasonable attorney or collection fees incurred in the collection of these charges.

I have read and understand the above financial policy:

____ ______________________________________ / ____________

Print Name **Signature of Patient/Responsible Party** **Date**

Vanguard Sleep Disorders Center LLC.

Patient Rights and Responsibilities

As a patient of Vanguard Sleep Disorders Center, you may exercise your rights as a client or have your authorized, designated representative exercise your rights as a client. Please remember that we must have written consent from you on file before we can release or discuss any information pertaining to your care or your account to anyone other than you, the patient. Please read over the patient rights and responsibilities below, initial beside each one and sign and print your name below.

1. ________**(Initial)** To receive appropriate care and services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference, physical or mental handicap, or personal cultural and ethnic preferences and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by agency staff.
2. ________**(Initial)** To be informed verbally upon request and in writing of billing and reimbursement methodologies prior to the start of care and as changes occur, including fees for services and products provided, direct pay responsibilities, and notification of insurance coverage. I understand it is also my duty to inform Vanguard Sleep Disorders Center LLC of insurance plan changes, address changes, telephone changes and primary and specialist physician changes
3. ________**(Initial)** To participate in the development and modification of your care and service plan; to refuse treatment, within the boundaries set by law.
4. ________**(Initial)** To review the Vanguard Sleep Disorders Center LLC privacy notice.
5. ________**(Initial)** To express concerns or grievances or recommend modification to your services without fear of discrimination or reprisal and to be involved, as appropriate, in discussions and resolutions of conflicts and/or ethical issues related to your care.
6. ________**(Initial)** To provide legitimate identification to Vanguard Sleep Disorders Center LLC.
7. ________**(Initial)** To not receive any experimental treatment without your specific agreement and full understanding of information explained.
8. ________**(Initial)** To be fully informed of your rights and responsibilities.
9. ________**(Initial)** I understand a copy of my sleep study is sent to my referring physician only.
10. ________**(Initial)** To provide complete and accurate information concerning your present health, medication, allergies, etc. when appropriate to your care/service.
11. ________**(Initial)** To involve you, as needed and as able, in developing, carrying out, and modifying your care plan, such as properly cleaning and storing your equipment and supplies, and following physician's orders.
12. ________**(Initial)** To request additional assistance or information on any phase of your health care plan you do not fully understand.
13. ________**(Initial)** To notify your attending physician when you feel ill, or encounter any unusual physical or mental stress or sensations.
14. ________**(Initial)** To notify Vanguard Sleep Disorders Center LLC when you will not be able to come to a scheduled appointment.
15. ________**(Initial)** To notify Vanguard Sleep Disorders Center LLC of any changes in your place of residence, telephone number and insurance information.
16. ________**(Initial)** To notify Vanguard Sleep Disorders Center LLC when encountering any problem with your equipment or service.
17. ________**(Initial)** To notify Vanguard Sleep Disorders Center LLC if you are to be hospitalized or if your physician modifies or discontinues your prescription for durable medical equipment.
18. ________**(Initial)** To select those who provide you with home medical equipment and to receive services promptly and professionally.

______________________	______________________	____________
Print Name	**Signature**	**Date**

VANGUARD SLEEP DISORDERS CENTER

17B Marshellen Drive
Beaufort, SC 29902
Phone: 843-962-0714
Fax: 843-941-3720

Sleep Disorder Risk Assessment Screening

Patient Name: ______________________ Date of Birth: ______________
Height: ____________ Weight: ______________ Neck Size: _______ Gender: ☐ M ☐ F
Address: ______________________ City: __________ State: ________ Zip: _______
Insurance Carrier: ______________________ Insurance ID: ______________

STOP BANG Screener (Mark Yes Or No)	YES	NO
Snore Do you snore loudly?	☐	☐
Tired Do you often feel tired, fatigued or sleepy during the day or wake up feeling like you haven't slept?	☐	☐
Observed Have you been told that you stop breathing or gasp for air or choke while sleeping?	☐	☐
Pressure Do you have or are you being treated for high blood pressure?	☐	☐
BMI Is your body mass index greater than 28?	☐	☐
Age Are you 50 years old or older?	☐	☐
Neck If you are a male, is your neck circumference greater than 17 inches? If you are a female, is your circumference greater than 16 inches?	☐	☐
Gender Are you a male?	☐	☐

SCORE: Patients with a STOP-Bang score of **0 to 2** can be classified as low risk for moderate to severe OSA whereas those with a score of 5 to 8 can be classified as high risk for moderate to severe OSA. In patients whose STOP-Bang scores are in the midrange (3 or 4), further criteria are required for classification.

NOTE: The STOP-BANG questionnaire screens for obstructive sleep apnea (OSA) only, not central sleep apnea.

Epworth Sleepiness Scale (Rate with 0-3)

How likely are you to doze off or fall asleep in the situations described below in contrast with just feeling tired? This refers to your usual way of life in recent times, not how you have felt in the past. Even if you haven't done some of these things recently, try to work out how they would affect you if you did. Use the following scale to choose the most appropriate number for each situation.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

	0	1	2	3
Sitting and reading.	☐	☐	☐	☐
Watching TV.	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a movie theater or a meeting).	☐	☐	☐	☐
Sitting in a car as a passenger for a continuous hour.	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit.	☐	☐	☐	☐
Sitting and talking to someone.	☐	☐	☐	☐
Sitting quietly after lunch without alcohol.	☐	☐	☐	☐
Sitting in a car stopped in traffic for a few minutes.	☐	☐	☐	☐
Total				

SCORE: 0-10 Normal Range of Sleepiness
10-12 Mild Sleepiness
12-24 Excessively Sleepy

NOTE: The Epworth questionnaire is used to provide a measurement of the general level of daytime sleepiness.

Vanguard Sleep Disorders Center LLC.

NAME:____________________________________TODAY'S DATE:_____________AGE:________DOB: ______________

Please list all of your current medications, strength, dosage, and date prescribed in the table below. If needed, please attach a separate sheet if there is not enough space below. Thank you.

MEDICATION	STRENGTH	DOSE	DATE PRESCRIBED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list all of your Physicians below.

List of Physicians that you see	Specialty	Last time seen	Still actively seeing ?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			