SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Murfreesboro 1725 Medical Center Pkwy, Ste 220, Murfreesboro (615) 893-4896
StoneCrest 515 StoneCrest Pkwy, Ste 200, Smyrna (615) 220-0366
Murfreesboro Medical Clinic 1272 Garrison Drive, Ste 301, Murfreesboro (615) 907-3336
Cool Springs (Dr. Silas' Office) 1608 Westgate Circle, Ste 100, Brentwood (615) 221-7777
Cool Springs Lab (Sleep Studies) 3326 Aspen Grove Dr, Ste 260, Franklin (615)942-1393
Nashville 4230 Harding Rd., Ste 523, Nashville, TN 37205 (615) 823-1027

PATIENT: Name ____

Birthdate _________________ Age ____ Social Security Number __________________________ Sex: M F

Address __________________________________ City _______________________ St _____ Zip ________

Primary Phone __________________Cell Home Secondary Phone ___________________ Cell Home

Work Phone ____________________ **Marital Status:** M S D W

Language: English, Russian, Spanish, Indian (includes Hindi & Tamil), or Other.

Race: American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, White, Hispanic, Other Race, Other Pacific Islander, Unreported/Refused to Report.

Ethnicity: Hispanic or Latino, Not Hispanic or Latino, Unreported/Refused to Report

I was referred here by Dr. __________________________ Primary Care Dr.___________________________

Pharmacy ______________________ Pharmacy Address ____

Occupation/how long ________________________________ Employer ______________________________

I heard about you from: My doctor, Phone book, Newspaper, Internet, Radio, Family Friend, other__________

INSURED: IF OTHER THAN PATIENT

Name ____ Birthdate _________________ Age ________

Address __________________________________ City _______________________ St _____ Zip ________

Social Security Number ______________________________________ Marital Status: M S D W Sex: M F

EMERGENCY CONTACT: Name ______________________ Phone ___________ Relationship __________

INSURANCE: EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)
I, the above named patient, hereby authorize that any and all benefits due from my insurance company,

Primary:______________________________ CMS (Policy / ID No. ________________________________),

Secondary:____________________________ CMS (Policy / ID No. ________________________________),
be made payable to Sleep Centers of Middle Tennessee, PLLC for any and all services rendered to me by any of its providers. I further authorize the release of any medical information to the above mentioned insurance company that is deemed necessary to determine and pay benefits on my behalf.

Signature ____ Date ______________

RELEASE:
I, the above named patient, authorize Sleep Centers of Middle Tennessee, PLLC or any of its agents, to release any and all of my medical information and appointment information to:
Name ____ Relationship _________________________

Name ____ Relationship _________________________

Signature ____ Date ______________

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MEDICARE SECONDARY PAYER INFORMATION

If you have Medicare Insurance as your secondary form of insurance, Sleep Centers of Middle Tennessee needs to know your reason for having Medicare as a secondary to properly file claims.

Complete this form only if you have Medicare as your Secondary Insurance provider.

Patient Name: ____

Please check the reason you have Medicare as your Secondary Insurance. Please check only one reason.

_____ You or your spouse are employed with an employer group health plan

_____ Disability under age 65

_____ End-Stage Renal Disease

_____ Veteran's Administration

_____ Black Lung

_____ Worker's Compensation

_____ No-Fault, including auto/other

_____ Other Liability Insurance

I, the above named patient, state that the above reason for Medicare or CMS as my secondary insurance is correct.

Signature: _____________________________________Date: ________________________

NOTICE OF PRIVACY PRACTICES

Sleep Centers of Middle Tennessee is required by the law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulation. The Privacy Officer will also take your complaints and can give you information about how to file a complaint. Our Privacy Officer is Craig Salazar. You can contact the Privacy Officer by phone at 615-893-4896 during regular business hours.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.
- We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

- You may ask us to restrict the use and disclosure of certain information in your record that would otherwise be allowed for treatment, payment, or health care operation. However, we do not have to agree to these restrictions.
- You have the right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternate address, please notify us.
- You have the right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.
- If you believe information in your record is inaccurate or incomplete, you may request an amendment. Your request must be in writing.
- You have the right to request an accounting of certain disclosures made by us.
- You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

I have read and understand all of the information contained in this Notice of Privacy Practices which is also available on the "Privacy" page of the Sleep Centers of Middle Tennessee website. I understand that I am entitled to have a copy of these practices at any time, and that I may contact the privacy officer with any questions regarding the privacy practices of the Sleep Centers of Middle Tennessee.

Patient (or representative): ____ Date _____________________

Signature (patient or representative): ____

If you are a representative of the patient, what is your relationship to the patient? ________________________

Version 1.5 / Effective 5/1/06

SLEEP CENTERS OF MIDDLE TENNESSEE
COMMUNICATION PREFERENCES AND RELEASE FORM

Appointment Reminder
How would you like to be contacted regarding your upcoming appointments?

Home phone_______ Cell Phone_______ E-mail________ Text Message__________

E-mail
We have found that sending information via e-mail is a quick, inexpensive and effective way to reach our patients with vital information, including appointment reminders and surveys. Occasionally we may send data on the latest technology, such as new equipment and medications, as well as informative articles on the most up-to-date surgical procedures available. To this end we are requesting that you provide us with your e-mail address. Your e-mail address will be kept confidential, and will not be shared with any third party. Our aim in communicating via e-mail is to enhance the quality of your care.

Patient Name: ____ Birthdate: ______________

E-mail address: ____

I hereby authorize Sleep Centers of Middle Tennessee to use my e-mail address to send me the following information:

_____ Sleep Center Information and Surveys

_____ Other information that may be pertinent to my care

Electronic Medical Records
SCMT has the ability to provide access to your Electronic Medical Record to you via a HIPPA compliant site. If you would like access to this feature please indicate so below.

Would you like access your Electronic Medical Record online? Yes ___________No____________

Signature: ____ Date: ______________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Purpose of Form: *This form provides patient consent for Sleep Centers of Middle Tennessee to receive protected health information from patient's other physicians.*

Patient Name___________________________________ Date of Birth _______________________

Person or Organization Disclosing the Information:

	Name	Address	City, State, Zip
1.			
2.			
3.			
4.			

Person or Organization Receiving the Information: **Sleep Centers of Middle Tennessee, PLLC**
Fax (615) 893-4821

Murfreesboro (615) 893-4896
StoneCrest (615) 220-0366
Murfreesboro Medical Clinic (615)893-4896
Cool Springs (615)942-1393
Nashville (615) 893-1027

Specific Description of the Information to be disclosed: **COMPLETE MEDICAL RECORDS**

The Purpose of this request is: **DIAGNOSIS AND TREATMENT BY SPECIALIST PHYSICIAN**

This authorization will expire on: Date: NONE OR when the following occurs: **PATIENT IS DISCHARGED**

WE DO NOT USE OR RELEASE ANY INFORMATION FOR MARKETING PURPOSES.

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

____ _____________________
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:_______________________________________

SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

MURFREESBORO
STONECREST
MURFREESBORO MEDICAL CLINIC
COOL SPRINGS
NASHVILLE

William H. Noah, MD John K. Mori, MD Russell Gibson, MD Steven L. Silas, MD
Robert W. McCain Timothy J. Hoelscher, PhD. Brian M. Wind, PhD. Renata Alexandre, RN, PhD.

FINANCIAL POLICY

We are happy that you have chosen Sleep Centers of Middle Tennessee to provide your healthcare needs. We are committed to providing the best care and service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be glad to answer any questions you may have.

We participate in most insurance plans, but due to continuing changes within the insurance industry, we cannot guarantee that your services will be covered. However, we will work with you and your insurance company to come to an agreement if we are not contracted with your carrier. As most insurance companies do not require pre-certification for our services, it is the patient's responsibility to check to see if predetermination is required. Our staff will provide pertinent information upon request.

We will file all claims to the patient's insurance company(s) upon receipt of all required information and releases. You will not be sent a statement until after we have received payment or denial from the insurance. All statements are due and payable upon receipt. Insurance payment authorizations are included in your paperwork. Should you refuse to sign the authorization to have your insurance benefits paid to us, you will be responsible for paying the total of your charges at the time of service.

It is the patient's responsibility to ensure that Sleep Centers of Middle Tennessee is a contracted provider for his/her insurance.

________, I understand that the contract between me and the insurance company provides that all co-payments
(initials) are due and payable at the time of service and that service can be denied if I am not prepared to pay my co-pay per the contract between my insurance company and the provider. (discretionary on a case by case basis)

Unless prior arrangements have been made, those who are uninsured are expected to pay at the time of the service.

We accept MasterCard and Visa for your convenience.

I have read, understand, and agree to abide by the above policies.

_______________________________ _______________
Print Name Date of Birth

_______________________________ _______________
Signature Date

_______________________________ _______________
Witness Date

EPWORTH SLEEPINESS SCALE

Name: ______________________________ Date: ____________________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. 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 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing
1) Sitting and reading?	____________
2) Watching TV?	____________
3) Sitting inactive in a public place (e.g., theater, meeting)?	____________
4) As a passenger in a car for an hour without a break?	____________
5) Lying down to rest in the afternoon when circumstances permit?	____________
6) Sitting and talking to someone?	____________
7) Sitting quietly after a lunch without alcohol?	____________
8) In a car, while stopped in traffic for a few minutes?	____________

SCORE: ____________

Questions © M. W. Johns 1990-1997

MEDICATION LOG

PATIENT INFORMATION			
Name:	**Date of Birth:**	**Preferred Phone Number:**	
Home Address: (Street, City, State & Zip)		**Secondary Phone Number:**	
Physician:	**Physician's Phone Number:**	**Pharmacy:**	**Pharmacy's Phone Number:**

CURRENT MEDICATION REGIMEN		
MEDICATION	**DOSAGE**	**SPECIAL NOTES**