Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Patient Name: _____ **Date of Birth**: ____ /____ / ____ **Last 4 of SSN**: _____

Current Mailing Address: _____ # _____

City: _____ **State**: _____ **Zip Code**: _____

Secondary Address: _____

Home ( ) _____ - _____ **Work** ( ) _____ - _____ **Cell** ( ) _____ - _____

Gender: ☐ Male ☐ Female ☐ Other **Relationship Status**: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Race: ☐ African American (Black) ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian (White)
☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Other _____

Ethnicity: Hispanic/Latino/Spanish origin ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other (please specify) _____

EMERGENCY CONTACT INFORMATION

***Name**: _____ **Relationship**: _____ **Phone:** ( ) _____ - _____

Primary Care Physician: _____ **Phone:** ( ) _____ - _____

Complete the information below if you DO NOT HAVE a current insurance card at time of appointment.

PRIMARY INSURANCE:

Insurance Carrier: _____ **Insurance Billing Address:** _____

Group #: _____ **Member ID:** _____

Policy Holder (if not self): _____ **Policy Holder DOB:** _____ / _____ / _____

SECONDARY INSURANCE:

Insurance Carrier: _____ **Insurance Billing Address:** _____

Group #: _____ **Member ID:** _____

Policy Holder (if not self): _____ **Policy Holder DOB:** _____ / _____ / _____

Worker's Comp: ☐ Y ☐ N **Auto Accident:** ☐ Y ☐ N **Date of Injury:** _____ / _____ / _____

W/C Office: _____ **Claim #:** _____

Adjuster's Name: _____ **Adjusters Phone:** ( ) _____ - _____ ext. _____

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_____/_____/_____

MEDICAL HISTORY

Is there a possibility that you may be pregnant? ☐ Yes ☐ No
Are you currently receiving palliative care? ☐ Yes ☐ No
**Palliative care is specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious or life-threatening illness, no matter the diagnosis or stage of disease.*

Have you been vaccinated for either of the following?
Influenza ☐ Yes ☐ No If yes, date of vaccination (*mm/dd/yy*) _____
Pneumococcal ☐ Yes ☐ No If yes, date of vaccination (*mm/dd/yy*) _____

PAST MEDICAL HISTORY

Do you currently have or have you ever had any of the following (choose all that apply):

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Have you ever had a sleep study conducted? ☐ Yes ☐ No

If yes, please answer the following questions:

What year was your sleep study conducted:_____ Were you diagnosed with sleep apnea? ☐ Yes ☐ No

Have you ever been treated with positive airway pressure (PAP) therapy? ☐ Yes ☐ No

If yes, did you bring your SD card or PAP therapy machine with you today? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following: ☐ Insomnia ☐ Narcolepsy ☐ Deviated Septum

Are you currently taking or have you ever taken medication to help you sleep? ☐ Yes ☐ No

If yes, which please list the medication(s): _____

How long did you take these medications?

Neuro Diagnostic Sleep Centers

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_____/_____/_____

SOCIAL HISTORY

Smoking Status: ☐ Smoker ☐ Occasional Cigarette Smoker ☐ Ex-Smoker ☐ Non-Smoker

Frequency: ☐ Light (1-9 Cigarettes/day) ☐ Moderate (10-19 Cigarettes/day)
☐ Heavy (20-39 Cigarettes/day) ☐ Very Heavy (40+ Cigarettes/day) ☐ Chain Smoker

Other Tobacco Use: ☐ Chews Tobacco ☐ Cigar Smoker ☐ Pipe Smoker ☐ Cigar Smoker ☐ Snuff User

Do you drink alcohol? ☐ NO ☐ YES If yes, ☐ Beer ☐ Wine ☐ Liquor/Mixed Drinks
_____ times per day/week/month/year (please circle)

CURRENT MEDICATIONS

☐ ***No current medications***

Please include all medications including over the counter medications and supplements

Name of Medication	***Strength/Dosage***	***Frequency***	***Method (Oral, topical, nasal, intravenous, intramuscular, inhalation, sublingual, etc.)***

ALLERGIES

☐ ***NO KNOWN ALLERGIES***

_____ _____ _____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Symptoms	X	Sleep Habits	Time
Loud snoring		At what time do you usually get in the bed?	
Breathing or snoring stops in my sleep		How long does it take you to fall asleep after you have turned out the lights?	
Awaken gasping for breath		How often do you awaken each night?	
Become sleepy during the day		Total time I spend awake in bed?	
Difficulty falling asleep		I usually wake up from sleep at?	
Difficulty remaining asleep		What time do you get out of bed from sleep?	
Awaken too early		Indicate total length of naps daily?	
My mind races with many thoughts when I try to fall asleep		If you do rotating shift work, or have other work schedule changes and need more space to describe?	
I often worry whether or not I will be able to fall asleep		**Epworth Sleepiness Scale**	
Fatigue			
Awaken with a dry mouth			
Vivid or lifelike visions (people in room, etc.) as you fall asleep or wake up		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	
Irritability/ Depression			
Memory impairment or Inability to concentrate		**Situation**	**Score**
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep		Sitting and reading	
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep		Watching TV	
Pain which delays, prevents, or awakens me from sleep		Sitting, inactive, in a public place(e.g., a theater or a meeting)	
Inability to move as you are trying to go to sleep or wake up		As a passenger in a car for an hour without a break	
Morning headaches		Lying down to rest in the afternoon	
Sudden weakness or feel your body go limp when you are angry or excited		Sitting and talking with someone	
Irresistible urge to move legs or arms		Sitting quietly after a lunch without alcohol	
Creeping or crawling sensation in your legs before falling asleep		In a car, while stopped for a few minutes in traffic	
Legs or arms jerking during sleep			
Frequent urination disrupting sleep		**Total***	
Sleep talking or Sleep walking		*Greater than 10 indicates sleepiness	

Neuro Diagnostic Sleep Centers

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_____/_____/_____

Review of Symptoms

Please Check ALL That Apply

CARDIAC	Chest Pain		Murmur(s)		Palpitation(s)	
CONSTITUTIONAL	Fatigue		Fever		Sleep Disorders	
	Weight Gain		Weight Loss			
EARS,NOSE,THROAT	Difficulty Swallowing		Hearing Aids		Ringing In Ears	
	Ear Pain		Hearing Loss			
ENDOCRINE	Diabetes		Thyroid			
EYES	Blurred Vision		Double Vision		Eye Pain	
GASTROINTESTINAL	Abdominal Pain		Constipation		Heartburn/Reflux	
	Bowel Incontinence		Diarrhea		Vomiting	
HEMATOLOGIC	Anemia		Easy Bruising			
INFECTIOUS	AIDS / HIV		Scabies		Tuberculosis	
	Hepatitis		Sexually Transmitted Disease(s)			
MUSCULOSKELETAL	Joint Pain		Muscle Pain		Other	
NEUROLOGICAL	Difficulty with Speech		Fainting/Black Out		Numbness	
	Difficulty Using Hands		Headache(s)		Seizures	
	Difficulty Walking		Memory Loss		Tingling	
	Dizziness		Muscle Weakness		Tremors	
PSYCHIATRIC	Anxiety		Bi-Polar Disorder		Depression	
RESPIRATORY	Asthma		Chronic Cough		Shortness of Breathe	
UROLOGIC	Kidney Stones		Painful Urination			
	Prostate Disorder		Urinary Hesitation			

FINANCIAL POLICY

As a courtesy, our facility will submit a claim to your insurance carrier on your behalf. However, practical benefits are not determined until a claim is received by your insurance company. When requested, we will provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, payment is due in full at the time of service. Patients may apply for CareCredit healthcare financing and arrange a payment plan if approved by CareCredit.

Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. (dba: NeuroDiagnostic Laboratories, LLC).

A Non-sufficient Funds (NSF) Fee of $25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

I understand that if my account is sent to an outside collection agency, I will be responsible for collection fees, which may be an additional 33% of the balance due.

A no call, no show (NCNS) fee of $100 will be applied to the patient and/or responsible party if the patient fails to call to cancel their appointment or cancels their appointment less than 24-hours prior to scheduled appointment time. The NCNS fee for an in-lab sleep study is $250 and the patient must cancel their appointment 72-hours prior to their scheduled appointment to avoid incurring the fee.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd. / NDL, LLC and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment(s) and coverage for services and/or supplies provided to me by AMDx, Ltd. / NDL, LLC.

NeuroDiagnostic Laboratories
Corporate offices
2423 W. Dunlap Avenue Suite 175
Phone: (602) 424-4450 Fax: (602) 424-4451

AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF

I further authorize AMDx Ltd., (dba. NeuroDiagnostic Laboratories) and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare if I am a Medicare beneficiary. I understand that in the event of an adverse decision made by my insurance carrier(s) as it relates to coverage, authorization or payment(s), AMDx Ltd., (dba. NeuroDiagnostic Laboratories) is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

Date: _____ / _____ / _____

Patient Name (printed) : _____ **Patient Signature**: _____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____ Representative Signature: _____

NeuroDiagnostic Laboratories
Corporate offices
2423 W. Dunlap Avenue Suite 175
Phone: (602) 424-4450 Fax: (602) 424-4451

NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS INTENDED TO DESCRIBE HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION

**** PLEASE REVIEW THIS INFORMATION CAREFULLY ****

1) **PURPOSE:** American Medical Diagnostics, Ltd (AMDx, Ltd.), dba. NeuroDiagnostic Laboratories (NDL) and their employees follow the privacy practices described within this notice. NDL maintain your health information and confidential records, as required by law. NDL may use, disclose or share your health information as pertains to your treatment, payment of services and the general healthcare operations, necessary to provide you with quality health care.

2) **WHAT ARE TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS? Treatment** may include sharing information with the other health care providers who are involved in your care. For example, your health care provider may need to share information about your condition with a pharmacist in order for you to receive medications. **Payment** may include use of your health information as required by your insurance carrier to obtain prior authorization, when applicable, and payment for services rendered. **Health Care Operations** may include limited use of your health information to help improve the quality of your care and/or for educational purposes as it relates to the training of NDL employees and staff.

3) **HOW WILL NDL USE OR DISCLOSE MY HEALTH INFORMATION?** Your health information may be used for the following reasons or disclosed to the following individuals and entities. *Note: You may refuse any/all communications outlined below, when shown with an asterisk (*)*.

- Family members or close friends who are involved in your care or payment for treatment, or to family members, a personal representative or another person responsible for your or regarding your location, general condition or death. (*)
- Disaster Relief Agency, if you are involved in a disaster relief effort (*)
- Information provided to you, regarding alternative treatments or services related to your health (*)
- Appointment Reminders
- Public Health Activities, such as; disease prevention, injury or disability, reporting of births/deaths, reporting adverse reactions to medications or product concerns, notification of recalls, infectious disease control, and notification to government agencies for suspected abuse, neglect or domestic violence
- Health Oversight Activities, such as; audits, inspections, investigation and licensure
- For Public Safety and Law Enforcement Activities, such as reporting crime in an emergency, a death that we suspect may have resulted from criminal conduct, to report a crime at one of our facilities, or to report information about a victim of a crime
- Marketing involving treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers or settings, to describe a health related product or service included in a plan or benefits. NDL will obtain your authorization prior to using or disclosing your health information for purposes of marketing items or services to you if it is paid to make the communication. You may revoke your authorization by making a written request to NeuroDiagnostic Laboratories 2423 W. Dunlap Ave. Suite 175 Phoenix, AZ 85021
- To assist Coroners, Medical Examiners and Funeral Directors in carrying out their job duties
- Organ and Tissue Donation
- Certain Research Projects or for reviews preparatory to research
- Disclosures necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public
- If the disclosure is required by federal or state law, such as in the case of child neglect or abuse reporting
- Military Command Authorities, if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized person who use the disclose to conduct special investigations
- Worker's Compensation Payers, as it relates to any injury and/or illness reported to or by a worker's compensation office
- For judicial or administrative proceedings if ordered by a court or in response to a subpoena
- To a correctional institution or law enforcement official if you are in inmate of a correctional facility or are under the custody of a law enforcement official to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.
- Use or disclosure necessary to initiate and complete health care treatment, payment and operations or functions by business associates, such as; installation of a new computer software system

Note: **Information with Additional Protection:** Certain types of medical information have additional protection under Arizona law. In some circumstances, we will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

4) **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except where otherwise described, use and/or disclose of your medical information will be not be released by NDL. If you would like us to release your medical information to a party/parties not otherwise mentioned, your request must be provided in writing and will only be effective as of the date you indicate. In addition, NDL require your written authorization to use or disclose your psychotherapy notes or to sell your health information. You may revoke any authorization to use or disclose your health information at any time by contacting [**insert contact info**], however, you understand that NDL may have already acted on your authorization to use or disclose your health information.

5) **WHAT ARE MY RIGHTS REGARDING MY HEALTH INFORMATION?** You have the following rights, when requested on the form(s) provided by NDL:

- **The Right to Request Restrictions:** You may request certain limitations on the usage or disclosure of your health information in relation to your health care, treatment, payment or operations. However, we are not required to comply with these types of requests, unless you request that we do not share your health information with your health insurer about a service for which you (or someone other than your insurer) has paid us in full and the disclosure is for the purpose of carrying out payment or health care operations and the disclosure is not otherwise required by law.
- **The Right to Confidential Communications:** You may request that communication regarding your health information be provided in a certain way or at a location, other than the personal address you provided. When submitting such a request, you must also provide a written method of contact for yourself; i.e., alternate phone number or address.
- **The Right to Inspect and Copy:** You may review and request a copy of your medical or health record(s). For certain requests, an administrative fee to cover the cost of the request may be applied. Under limited circumstances, your request may be denied. You then have the right to request review of the denial by another licensed health care professional, as selected by NDL. After the review is completed, NDL will comply with the outcome.
- **The Right to Request Amendment:** You may request an amendment to your medical or health record(s), if you believe that information maintained by NDL is incorrect or incomplete. However, we are not required to accept the amendment.
- **The Right to Accounting of Disclosures:** You may request a list of some of the disclosures made by AMDx Ltd./NDL of your health information. NDL may apply an administrative fee for any request received after the initial request.
- **The Right to a Copy of This Notice:** You may request a paper copy of this notice at any time, even if you have been provided with an electronic copy. To obtain an electronic copy of this notice, please refer to our website, at: www.ndxlabs.com.
- **To Be Notified in the Event of a Breach**. In the event AMDx. Ltd./NDL determine that the confidentiality of your health information has been breached, you have the right to be notified.

6) **WHAT REQUIREMENTS APPLY TO THIS NOTICE?** NDL is required by law to provide you with this notice and will continue to comply with the provisions outlined within, for as long as it is required by law. NDL reserves the right to change the terms outlined within this notice and any such changes will be effective for all information that may be in our health records for you, as well as for all future information we receive for or by you. All revisions to this notice will be available on our website, at www.ndxlabs.com. Revised paper copies will also be available, upon request. A copy of the notice may be provided to you, each time you register to receive services by NDL.

7) **WHAT IF I HAVE A COMPLAINT REGARDING PRIVACY PRACTICES?** If you believe your privacy rights have been violated, you may file a complaint with the NDL Privacy Officer or with the Secretary of the United State Department of Health and Human Services. All complaints must be submitted in writing and must describe the details / situation that caused the complaint. You will not be penalized or retaliated against for filing a complaint to NDL or to the Department of Health and Human Services.

NeuroDiagnostic Laboratories
ATTN: Privacy Officer
2423 W. Dunlap Ave | Suite 175
Phoenix, AZ. 85021-5818
(P) 602.424.4450 | (F) 602.424.4451

A. An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
   a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
   b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:
   a. Abuse;
   b. Neglect;
   c. Exploitation;
   d. Coercion;
   e. Manipulation;
   f. Sexual abuse;
   g. Sexual assault;
   h. Except as allowed in R9-10-1012(B), restraint or seclusion;
   i. Retaliation for submitting a complaint to the Department or another entity; or
   j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
3. A patient or the patient's representative:
   a. Except in an emergency, either consents to or refuses treatment;
   b. May refuse or withdraw consent for treatment before treatment is initiated;
   c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
   d. Is informed of the following:
   i. The outpatient treatment center's policy on health care directives, and
   ii. The patient complaint process;
   e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
   f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
   i. Medical record, or
   ii. Financial records.

C. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, Strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S.§§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other

Submit Complaints in writing to: NeuroDiagnostic Labs
Attn: Erica Boehle
2423 W. Dunlap Ave #175
Phoenix, AZ 85021

Acknowledgement of Receipt of Notice of Privacy Practice And Patient Rights Form

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories, LLC (AMDx) Notice of Privacy Practices and Patient Rights Form. AMDx maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein.

Any questions you have regarding the information provided in the AMDx Notice of Privacy Practices or Patient Rights Forms should be directed to AMDx Administrative staff or the Privacy Officer indicated on the Privacy Practice.

I understand that certain disclosures are required under federal law and may be released by AMDx, upon request from an authorized entity, as outlined below:

- Public Health Activities
- Health Oversight Activities
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Certain research projects
- Disclosures necessary to prevent serious threats to health or safety
- Military Command Authorities; if you are a member of the armed forces or foreign military authority
- National Security and Intelligence
- Worker's Compensation Payers; and
- Disclosures necessary to initiate and complete health care treatment
- Payment and operations or functions by business associates

I further understand that the disclosures outlined below may be considered optional and that I may choose to 'opt out' of these types of disclosures by selecting '*decline'* for any or all circumstances below.

- Family members or close friends who are involved in your care or payment for treatment ☐ DECLINE
- Disaster Relief Agencies; if you are involved in a disaster relief effort; and ☐ DECLINE
- Information provided to you regarding alternative treatments for your health care ☐ DECLINE

I have been given, and have read and understand my rights under the Notice of Privacy Practices.
I have been given, and have read and understand my rights under the Patient Rights Form.

Patient Name (printed): _____

Patient Signature: _____ **Date**: _____/_____/_____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____ Representative Signature: _____

Appointment Date
_____/_____/_____

Sleep Study Consent

PSG, CPAP, BiPAP, MSL T and/or MWT

I have either self-referred or have been referred by my physician to AMDx, Ltd. (dba, NeuroDiagnostic Laboratories) for sleep therapy to further understand my medical condition.

Diagnostic sleep studies involve the placement of electrodes on the scalp, face, neck, chest, hand(s), and leg(s) to measure and record brain activity, heart activity, respiration, body movement, blood oxygen content, and rapid eye movement (REM) to determine levels of sleep. Patients will be monitored via audio and video using an infrared video camera and an intercom system.

The sleep technologist will not be able to share any information about the study with patients until the physician has reviewed all of the data collected. The sleep study results are typically available within one (1) week of the date of the study. Please keep in mind, every patient and their condition(s) are unique therefore not every sleep study will result in a confirmed diagnosis. There are no known side effects of this type of testing. The alternative to this type of testing is to not have it performed, where the information regarding a potential sleep disorder will not be obtained.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP STUDY

Patient Name (printed):_____**Patient Signature**: _____

If applicable, please print the name of the patient's representative:

_____, Relationship to the patient_____

Representative Signature: _____

Neuro Diagnostic Sleep Centers

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_____/_____/_____

Bedtime Questionnaire

Patient name: _____ DOB: _____/_____/_____

Please Complete All Sections and Print Clearly

Did you take any naps today? ☐ NO ☐ YES

Did you have any caffeinated beverages today? ☐ NO ☐ YES

If yes, at what time and how many?_____

Did you have any alcoholic beverages today? ☐ NO ☐ YES

If yes, at what time and how many?_____

Did you take any medications to help you stay awake? ☐ NO ☐ YES

If yes, what medication(s)?_____ At what time? _____

Did you take any sleep aids today? ☐ NO ☐ YES

If yes, what sleep aids?_____ At what time? _____

Patient Name (printed): _____

Patient Signature: _____ Date: _____/_____/_____

If applicable, please print the name of the patient's representative: _____

Relationship to the patient: _____

Representative Signature: _____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Morning Questionnaire

Patient Name:_____ DOB:_____/_____/ _____

Please Complete All Sections and Print Clearly

How long do you think it took for you to fall asleep last night? ☐ 0-30 Minutes ☐ 30-60 Minutes ☐ Longer

Compared to your normal sleep, how did you sleep last night? ☐ Better ☐ Same ☐ Worse

Compared to your normal sleep, how much sleep did you get last night? ☐ More ☐Same ☐ Less

Do you feel last night's sleep was adequate? ☐ NO ☐ YES

How many times do you think you woke up last night? ☐ Unsure ☐ Not at all ☐_____times

Please make **ONE** selection that best describes how you felt when you woke up this morning:

☐ Active, vital, alert, and awake

☐ Foggy, not able to concentrate

☐ Relaxed, awake, but not at full alertness

☐ Sleepy, fighting to stay awake

Did anything bother you during the night? ☐ No ☐ Yes

Explain:_____

Patient Name (printed):_____

Patient Signature: _____ Date:_____/_____/_____

If applicable, please print the name of the patient's representative:

_____, Relationship to the patient _____

Representative Signature: _____

Appointment Date
_____/_____/_____

Driving Recommendation and Acknowledgement

Driving while groggy, sleepy, and/or under the influence of any medication that may cause drowsiness can be dangerous, potentially leading to serious injuries or even death. It is the opinion and strong recommendation of the management, staff and/or other affiliates of AMDx, Ltd. (dba, NeuroDiagnostic Laboratories) that if you feel groggy or tired the morning following your sleep study that you arrange for alternative transportation home from the sleep facility. We are not responsible for any adverse actions or events that may occur should you choose to decline alternate transportation options.

As a courtesy to our patients, we provide a small selection of coffee at each sleep center. However, we do not offer breakfast items or food of any kind. If you require a meal or snack in the morning, please bring food with you.

I HAVE BEEN ADVISED OF AND FULLY UNDERSTAND THE DRIVING RECOMMENDATIONS MADE BY THE MANAGEMENT, STAFF AND/OR OTHER AFFILIATES OF AMDx, Ltd. (dba, NEURODIAGNOSTIC LABORATORIES) AND HAVE MADE THE FOLLOWING DECISION REGARDING MY TRANSPORTATION:

☐ I have arranged for alternative transportation (friend/family member, taxi, ride share, public transportation).

☐ I have DECLINED to arrange alternative transportation*

By DECLINING to arrange alternative transportation, I accept full responsibility for any adverse actions and/or events that may result from my decision.*

Patient Name (printed): _____

Patient Signature: _____ Date: _____/_____/_____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Morning Questionnaire

Patient Name:_____ DOB:_____/_____/ _____

Please Complete All Sections and Print Clearly

How long do you think it took for you to fall asleep last night? ☐ 0-30 Minutes ☐ 30-60 Minutes ☐ Longer

Compared to your normal sleep, how did you sleep last night? ☐ Better ☐ Same ☐ Worse

Compared to your normal sleep, how much sleep did you get last night? ☐ More ☐Same ☐ Less

Do you feel last night's sleep was adequate? ☐ NO ☐ YES

How many times do you think you woke up last night? ☐ Unsure ☐ Not at all ☐_____times

Please make **ONE** selection that best describes how you felt when you woke up this morning:

☐ Active, vital, alert, and awake

☐ Foggy, not able to concentrate

☐ Relaxed, awake, but not at full alertness

☐ Sleepy, fighting to stay awake

Did anything bother you during the night? ☐ No ☐ Yes

Explain:_____

Patient Name (printed):_____

Patient Signature: _____ Date:_____/_____/_____

If applicable, please print the name of the patient's representative:

_____, Relationship to the patient _____

Representative Signature: _____

Clinic Discharge Agreement

I, _____, understand that at the conclusion of my scheduled appointment today I am being released from the care of NeuroDiagnostic Laboratories and all results from my testing and/or recommendations from a consultation/visit today will be sent to my referring physician's office. It is my responsibility to follow-up with my physician to review these results and discuss any further healthcare needs.

Patient Name (printed): _____

Patient Signature: _____ Date: ___ / ___ / ___

If applicable, please print the name of the Patient's Representative: _____

Relationship to the Patient: _____ Representative Signature: _____

Witness Name (printed): _____ Witness Signature: _____

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