Health System

Huntsville Sleep Center
245 Governor's Drive SE
Huntsville, AL 35801
Phone 256-265-8553 Fax 256-265-7082

Madison Sleep Center
8020 Highway 72 W, Suite D
Madison, AL 35758
Phone 256-265-5977 Fax 256-722-3011

Dear _____,

Your initial evaluation has been scheduled with _____ on _____.

Please arrive at _____ AM/PM for your appointment at _____AM/PM.

The Huntsville Sleep Center is located inside the **WOMEN & CHILDREN'S HOSPITAL** (formerly Huntsville Hospital East) on the ground floor. You may park in any patient parking area around the Women & Children's Hospital. There is limited free parking in the front of the hospital. There is additional parking available in the lot beside the hospital for a $2.00 fee. Valet parking is also available for a $5.00 fee. The Sleep Center is able to validate under special circumstances ONLY. Please speak with the office staff when you arrive or call prior to your appointment for more information.

The Madison Sleep Center is located on the corner of Highway 72 West and Wall Triana Hwy, in the old Southern Family Market complex. We are beside Madison Hospital, Physical Therapy.

Please complete the enclosed paperwork and bring it with you to your appointment. You will also need to bring your insurance card(s) and a photo ID. We ask that you arrive 30 minutes early in order to process this paperwork into your medical records. If you are late by 10 minutes or more, your appointment may have to be rescheduled. **If you are scheduled for a 1:00 p.m. appointment, please do not arrive early as our office is closed for lunch from 12:00 – 1:00 p.m.**

Our office staff will contact you to confirm your appointment. **Please call us at least 24 hours in advance if you need to cancel or reschedule your appointment.** Excessive cancellations or no shows may only be rescheduled with the Sleep Center's physician's approval or a new referral.

Your initial evaluation allows you to speak with the doctor, one on one, regarding any symptoms and/or concerns you may have with your sleep. Plan to be here approximately an hour. If it is deemed necessary by the physician that you undergo sleep testing, an appointment will be scheduled before you leave the Sleep Center.

In consideration of those with breathing disorders and other sensitivities, we are a fragrance free facility. Please refrain from wearing perfume, scented lotions or cologne to any appointments or sleep testing.

Please contact us if we can be of further assistance. Our business hours are 8:00 a.m. - 4:30 p.m. Monday through Thursday, closed for lunch 12:00 - 1:00 p.m., and 8:00 a.m. - 12:00 noon Friday.

Sleep Center Registration

Patient Name_____ DOB_____
SS#_____ Marital Status (circle one) S M D W Sex M / F

Primary Care Physician _____

Race (circle one) Asian Black/African American White/Caucasian American Indian or Alaska Native
Hispanic/Latino Other Pacific Islander More than 1 race Do not wish to report

Preferred Language ___English ___Spanish ___French ___Creole ___Other _____

Address_____
City_____ State_____ Zip_____
County_____ Home Phone_____ Cell_____
Email Address_____

Employment Status (circle one) Full Part Self Retired Unemployed Active Duty Military
Employer_____
Address_____
City_____ State_____ Zip_____
Phone_____

Spouse Name _____ DOB _____
Address_____
City_____ State_____ Zip_____
Cell Phone_____ Work _____
Spouse Employer_____
Address_____
City _____ State_____ Zip_____

Emergency Contact _____Relationship to Patient_____
Address_____ _____
City_____ State_____ Zip_____
Phone_____ Work _____

Guarantor if other than Patient _____
Relationship_____ DOB_____ SS#_____
Address_____
City_____State_____ Zip_____
Home Phone_____ Cell _____Work_____

Primary Insurance
Subscriber Name _____Relationship to Patient_____
Insured SS#_____ DOB_____
Insured Employer _____
Address _____
City_____ State_____ Zip_____

Secondary Insurance
Subscriber Name _____Relationship to Patient_____
Insured SS#_____ DOB_____
Insured Employer_____
Address_____
City_____ State_____ Zip_____

Health System

HUNTSVILLE HOSPITAL AND MADISON HOSPITAL SLEEP CENTERS
PATIENT QUESTIONNAIRE

Please fill out this form completely. The information is confidential and will not be released to any person or company without your written permission.

Name _____ Date _____

Sex M F Date of Birth _____ Age _____
How did you hear about the Sleep Center? _____
Who is your primary physician? _____

Please explain the reason(s) you came to the Sleep Center_____
_____

How long have you had this problem? _____

Snoring

Do you snore? Y N
How long have you snored? _____
How does your family/others describe your snoring? _____

Do you stop breathing in your sleep? Y N
How often? Occasionally/when tired/when drinking alcohol/all the time/only on back

Sleep Patterns

What are your normal work hours? _____ to _____
What days do you normally work? _____
What time do you go to bed? _____
How long does it take you to fall asleep? _____
If you take more than 10-15 min to fall asleep what keeps you awake? _____
How often do you awaken during the night? _____
How long does it take to fall back asleep? ____
How many times do you use the bathroom at night? _____
What time do you awaken for the day? _____
How do you feel when you wake? _____
Does your schedule change on weekends/days off? _____

Daytime Function

How do you feel during the day? _____
Do you have problems staying awake at work? _____
Do you have problems staying awake when driving? _____
Do you nap during the day? _____ For how long? _____

Habits

Do you use:

alcohol?	Y	N	How much per day/week? _____
caffeine drinks?	Y	N	How much per day? _____
tobacco?	Y	N	How many packs per day? _____
medication to help you sleep?	Y	N	What kind and how much? _____
"nerve" medication?	Y	N	What kind and how much? _____
antidepressants?	Y	N	What kind and how much? _____
pain medication?	Y	N	What kind and how much? _____
antihistamines?	Y	N	What kind and how much? _____

Bedroom

Do you sleep with a bed partner?	Y	N
Is your bedroom:		
dark?	Y	N
quiet?	Y	N
comfortable?	Y	N
Is your sleep disturbed by:		
your bed partner?	Y	N
pets?	Y	N
children?	Y	N
Do you listen to radio or TV to fall asleep?	Y	N

General Heath

Has your weight changed in the last 5 years? Y N Gained _____lbs
Lost _____lbs

Have you have or been treated for:

Hypertension (high blood pressure)?	Y	N	How long?_____
Sinus disease/allergies?	Y	N	Seasonal or Year Round
Headaches?	Y	N	How often?_____
Anxiety or Depression?	Y	N	

Have you been evaluated by a psychiatrist or psychologist? Y N
When? _____ Where? _____

How is your health in general? _____

Treatment for Sleep

Have you used any of the following treatments for your sleep problems in the past?

Sleeping Pills?	Y	N
Antidepressants?	Y	N
Stimulants (Ritalin, Adderall, Provigil)?	Y	N
Surgery(sinus or throat)?	Y	N
CPAP or BIPAP ?	Y	N

Have you ever had sleep studies done before? Y N

When? _____ Where? _____

Pain Evaluation

Do you have any pain or discomfort now? Y N

Where? _____

What does if feel like? _____

How would you rate your pain ? (Use a scale of 0-10 0=none 10= severe) ___

Past Medical History (use back of paper if necessary)

Please list all operations and dates

_____
_____
_____
_____
_____
_____
_____

List all other hospitalizations and dates

_____
_____
_____
_____
_____
_____
_____

Family History

Is there a family history of:

Narcolepsy	Y	N	relationship _____
Insomnia	Y	N	relationship _____
Sleep Apnea	Y	N	relationship _____
Restless Legs	Y	N	relationship _____
Other Sleep Disorder	Y	N	relationship _____

Social History

What is your occupation? _____

If retired what did you do before retirement? _____

Marital status Married Single Widowed Divorced Separated Other

What is your highest education level? _____

Systems Review

Do you currently have problems with the following (circle all that apply):

weight loss?
weight gain?
recent fever?

glaucoma?
cataracts?

nasal polyps?
nasal fracture?
sinus problems?

hypertension?
chest pain?
pain in legs when walking?
swelling in legs/ankles?

asthma?
shortness of breath?
wheezing?
recurrent bronchitis?
emphysema?

hiatal hernia?
ulcers?
reflux or heartburn?
colon polyps?
hepatitis?

using bathroom at night?
blood in urine?
kidney stones?
kidney infections?

back pain?
arthritis?
restless legs?
legs jerking at night?
elevated thyroid?
low thyroid?
diabetes?
cancer?

headaches?
epilepsy/seizure?
meningitis?
polio?

anxiety?
depression?

vivid dreams?
sudden muscle weakness?
paralysis when asleep?

Medications and Allergies

Please list all current medications: (use back of paper if necessary)

Name of Medication	Dosage (mg or cc)	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to:

Medication(s)	Y	N	Please list drug and reaction (use back if needed)
_____			_____
_____			_____
_____			_____
_____			_____
_____			_____

Latex	Y	N	**Skin adhesives**	Y	N
Foods	Y	N	Environmental agents	Y	N

Please list food/agents and reaction _____
_____

The Epworth Sleepiness Scale

Name: _____

Today's Date_____**Your Age (years)**_____

Your Sex (male=M, female= F)_____

How likely are you to doze 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 (0-3)**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (without alcohol)	_____
In a car, while stopped in traffic	_____
Total	_____

HEALTH SYSTEM

HUNTSVILLE HOSPITAL & MADISON HOSPITAL SLEEP CENTERS

BILLING AND INSURANCE INFORMATION

Sleep disorders are recognized as medical problems. However, individual insurance carriers vary in their claim submission requirements and reimbursement policies. For this reason, the Sleep Center handles billing in the following manner:

OFFICE VISITS

The Sleep Center collects co-payments at the time of service. The amount of your copay is determined by your insurance company. Any questions regarding insurance coverage or status of your bill should be directed to your physician's private office.

***Dr. Robert Serio or Reiga Luedemann, MSM, PA-C:** Huntsville Lung Associates can be reached at 256-533-6003. Forms of payment accepted are cash, check, Visa, Master Card, Discover Card, and American Express.

***Dr. Darren Gannuch:** Alabama Sleep Disorder Center can be reached at 256-882-2003. Forms of payment accepted are cash or check only.

***Dr. Bahador Tafazoli**: Cullman Primary Care, Family/Sleep Medicine can be reached at 256-775-1090. Forms of payment accepted are cash and check only.

***In addition, Huntsville Hospital's business office will file a claim with your insurance for the services rendered by the hospital. For billing inquiries please call 256-265-9569.**

SLEEP CENTER TESTING

If testing is scheduled for you, we recommend that you contact your insurance carrier to verify coverage. **The Sleep Center does not verify coverage.** Some carriers may require prior authorization or precertification for your testing. **It is your responsibility to notify your physician and the Sleep Center if prior authorization or precertification is required for your services to be covered.**

If you find that your insurance carrier does not cover sleep testing, please contact us.

Diagnostic testing includes any procedure performed overnight or the next day. Any diagnostic procedure your physician orders will be explained prior to scheduling.

For insurance purposes the following codes are provided:

Procedure	Procedure Code	Procedure	Procedure Code
Adult Polysomnography (NPSG)	95810	Child Polysomnography (NPSG)	95782
Adult Polysomnography with CPAP/BIPAP	95811	Child Polysomnography with CPAP/BIPAP	95783
Multiple Sleep Latency Test (MSLT)	95805		
Maintenance Wakefulness Test (MWT)	95805		
ARES (Home testing device)	95800		
Overnight Pulse Oximeter (Home testing)	94762		

After your overnight sleep study you will receive two billing statements. One statement will be from the hospital for the diagnostic testing. The second will be for the interpretation fee from your physician. Please know that you may be scheduled for multiple procedures depending on your clinical condition. Any questions regarding the status of the bill should be directed to the phone number on your statement. Any questions regarding insurance coverage should be directed to your physician's private office.

***Huntsville Lung Associates:** 256-533-6003 for Dr. Serio

***Pulmonary and Sleep Assoc. of Huntsville, PC:** 256-883-2112 for Dr. Sneeringer or Dr. Vuppala

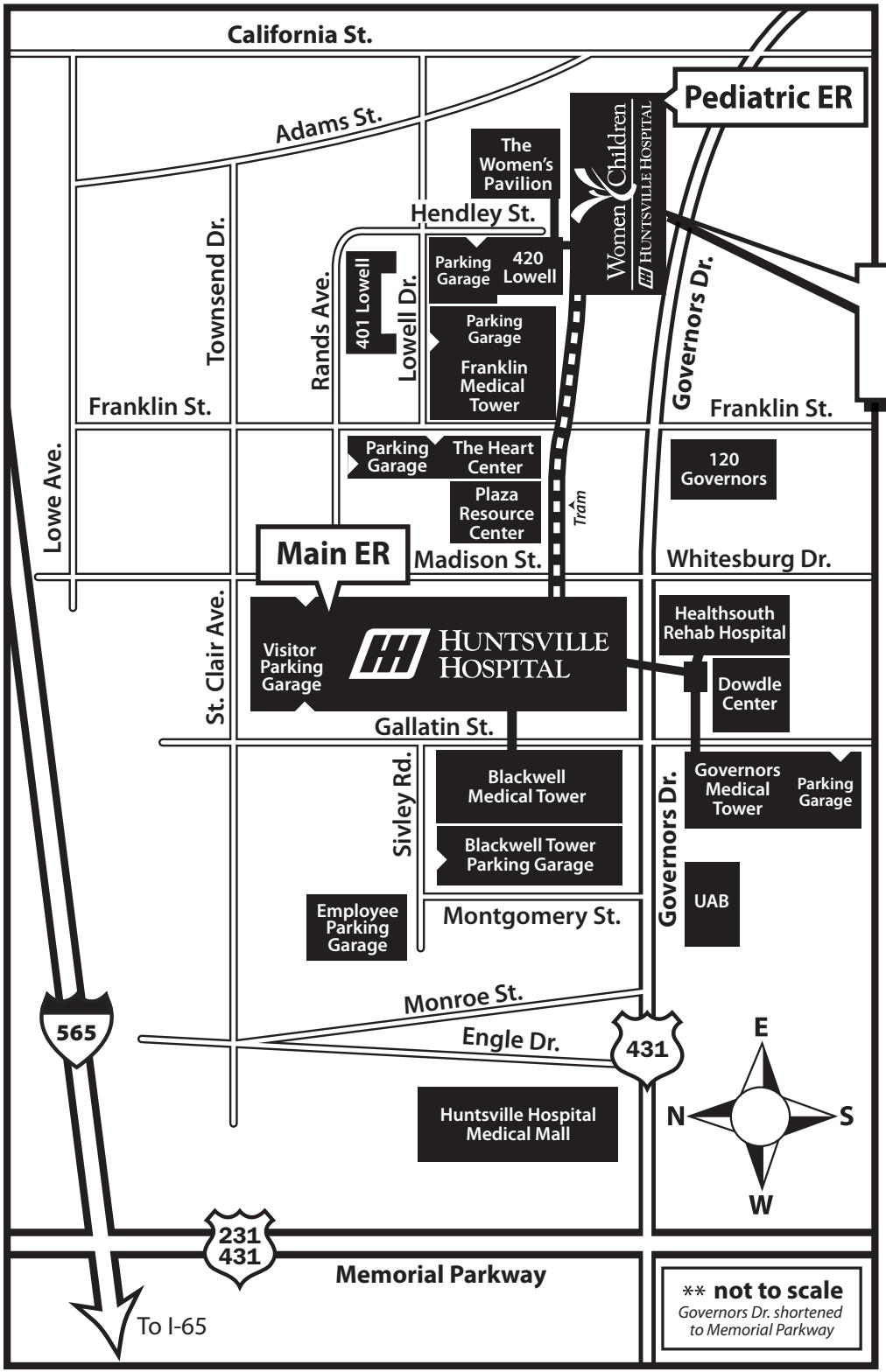
***Roy Sleep Medicine:** 256-213-1800 for Dr. Roy

***Alabama Sleep Clinic:** 256-539-2531 for Dr. Hearn

***Alabama Sleep Disorder Center:** 256-882-2003 for Dr. Gannuch

***Cullman Primary Care, Family/Sleep Medicine**: 256-775-1090 for Dr. Tafazoli

Revised: 1/20/15 DA



HUNTSVILLE HOSPITAL

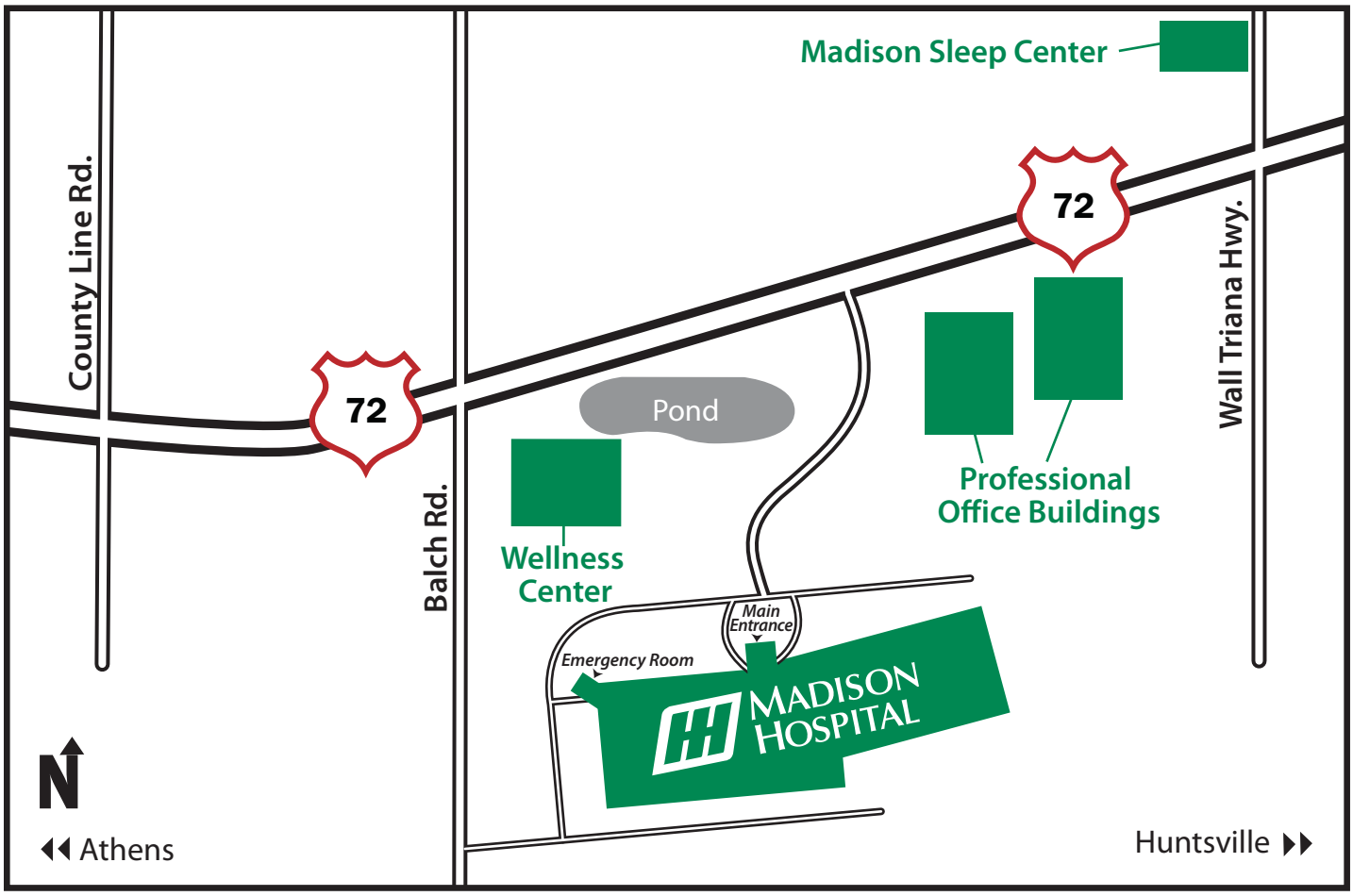
The Sleep Center
Ground floor
Women & Children Hospital

The Sleep Center is located on the Ground floor of
Huntsville Hospital for Women & Children
245 Governors Dr. SE
Huntsville, AL 35801
(256) 265-8553

Take the elevator in the main lobby to the ground level, turn left when you step off the elevator. We are down the first hallway to the left.

MADISON HOSPITAL

SLEEP CENTER



The Madison Sleep Center is located in the old Southern Family Market shopping center at the northwest corner of Hwy. 72 and Wall Triana.

8020 Hwy. 72 West
Suite D
(256) 265-5977