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________________
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(sinuses 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 it 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?
- 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?
- using bathroom at night?
- anxiety?
- depression?
- vivid dreams?
- sudden muscle weakness?
- paralysis when asleep?
- using bathroom at night?
- anxiety?
- depression?
- vivid dreams?
- sudden muscle weakness?
- paralysis when asleep?

### Medications and Allergies

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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage (mg or cc)</th>
<th>Reason</th>
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Are you allergic to:

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

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<tr>
<th>Medication(s)</th>
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- Latex  Y  N  Skin adhesives  Y  N

- Foods  Y  N  Environmental agents  Y  N

Please list food/agents and reaction

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<thead>
<tr>
<th>Food/Agent</th>
<th>Reaction</th>
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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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing (0-3)</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
<td>______________________</td>
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<tr>
<td>Watching television</td>
<td>______________________</td>
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<tr>
<td>Sitting inactive in a public place</td>
<td>______________________</td>
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<tr>
<td>(theater or a meeting)</td>
<td>______________________</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>______________________</td>
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<tr>
<td>Lying down to rest in the afternoon</td>
<td>______________________</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>______________________</td>
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<tr>
<td>Sitting quietly after lunch (without alcohol)</td>
<td>______________________</td>
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<tr>
<td>In a car, while stopped in traffic</td>
<td>______________________</td>
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</tbody>
</table>

Total  _____________________________________
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:

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

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
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.
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