

Mid-South Pulmonary Specialists, P.C.  
Sleep Center

Dear Patient:

You are scheduled to see one of our doctors at the Methodist Sleep Disorders Center located in the **White Station Tower at 5050 Poplar Avenue, Suite 300.**

**Please complete the enclosed questionnaire and sleep diary and bring them with you.** If you need assistance in completing these forms, please arrive at our office 15 minutes before your scheduled appointment and our staff will be happy to assist you.

We ask that you bring with you the following items:

- Any copay and/or any outstanding balance (we accept cash, check or credit card)
- All insurance information including referrals (if required by your insurance)

Please understand that we are a **SPECIALTY MEDICAL PRACTICE** and give all our patients quality medical care; therefore, you may experience a **LENGTHIER** wait than you are accustomed to. Please understand there will be a **\$20.00** fee for appointments not canceled 24 hours in advance.

If you have any questions or need to reschedule your appointment, please call us at (901)276-6507 between the hours of 8:00 a.m. and 4:30 p.m. We look forward to meeting you.

# MID-SOUTH PULMONARY SPECIALISTS

5050 POPLAR AVE. SUITE 800

MEMPHIS, TN 38157

(901) 276-2662

PATIENT INFORMATION					
NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)					
NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP		CITY, STATE ZIP			
HOME PHONE		HOME PHONE			
RELATIONSHIP TO PATIENT					

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		\$	
CITY, STATE ZIP		DEDUCTIBLE	
		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		\$	
CITY, STATE ZIP		DEDUCTIBLE	
		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I am responsible for my bill. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing.

I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

SIGNATURE OF PATIENT/GUARDIAN

DATE

**METHODIST LEBONHEUR HEALTHCARE  
SLEEP DISORDERS CENTER PATIENT QUESTIONNAIRE**

NAME. \_\_\_\_\_ DATE. \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Pharmacy Name and Phone: \_\_\_\_\_

**INSTRUCTIONS.**

The following questionnaire is for several different types of sleep disorders. As a result, there may be questions that will seem irrelevant to your particular complaint. However, we ask that you complete all questions, to provide as much information as possible to the physician that will be reviewing your test results. Most questions are written in "yes" or "no" fashion. There are some that have blank spaces provided for your answer and some ask you to circle the number that best correspond with your description of a particular situation. We are pleased to have the opportunity to provide this testing service to you.

**THE EPWORTH SLEEPINESS SCALE**

Use the following scale to rate how likely you are to doze or fall asleep during each of the following situations. This refers to your usual way of life in recent times.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

**Chance of Dozing**

Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (a theater, meeting, seminar)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
<b>Score:</b>	_____

THIS INFORMATION WILL BE HELD IN CONFIDENCE.

1. Describe your main problem(s) that brought you to a sleep specialist by checking all of the following that describe your signs, symptoms, and overall feelings.

- difficulty falling asleep  wake up during the night  wake up early in the morning
- excessive daytime sleepiness  difficulty awakening  high blood pressure
- headaches  dizziness  bowel disturbances  alcoholism  tremors
- fainting spells  job performance problems  stomach troubles  no appetite
- snoring  fall asleep or doze while driving  car accident from falling asleep while driving
- other problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. How long has this problem bothered you and how often does it occur?

- longer than 2 years  1 to 2 years  within the last 12 months
- almost every night  for periods of at least 1 week  irregularly
- other: \_\_\_\_\_

3. Do any other members of your family have sleep problems? Please explain:

4. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

- general practitioner  obstetrics/gynecologist  cardiologist  internist
- other: \_\_\_\_\_

5. What treatments have you received?

6. Please rate how often you:

	Never	Rarely	Sometimes	Frequently	Always
Awaken from sleep short of breath or gasping	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching, or coughing	_____	_____	_____	_____	_____

	Never	Rarely	Sometimes	Frequently	Always
Snore	_____	_____	_____	_____	_____
Snore so loud that others complain	_____	_____	_____	_____	_____
Have trouble sleeping when you have a cold	_____	_____	_____	_____	_____
Breathing problems at night (observed by self or others)	_____	_____	_____	_____	_____
Sweat excessively at night	_____	_____	_____	_____	_____
Notice your heart pounding, beating irregularly day or night	_____	_____	_____	_____	_____
Fall asleep during day	_____	_____	_____	_____	_____
Fall asleep during physical effort	_____	_____	_____	_____	_____
Fall asleep when laughing/crying	_____	_____	_____	_____	_____
Experience loss of muscle tone When extremely emotional	_____	_____	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Experience vivid dream-like scenes upon awakening or falling asleep	_____	_____	_____	_____	_____
Feel afraid of going to sleep	_____	_____	_____	_____	_____
Notice parts of your body jerk	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Have crawling/aching feelings in legs	_____	_____	_____	_____	_____
Have any type of leg pain at night	_____	_____	_____	_____	_____
Have morning jaw pain	_____	_____	_____	_____	_____
Grind teeth during sleep	_____	_____	_____	_____	_____
Wake with stiff, sore/aching muscles	_____	_____	_____	_____	_____
Wake with pain in neck, spine, joints	_____	_____	_____	_____	_____

- 7 Does your sleep problem disturb you sex life? (Please provide information on significant relationships.)
8. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?
- 9 How many hours of sleep do you usually get per night? \_\_\_\_\_
- 10 What time do you usually go to bed on WEEKDAYS? \_\_\_\_\_  
WEEKENDS? \_\_\_\_\_
- 11 How long does it take for you to fall asleep? \_\_\_\_\_
12. How many times do you typically wake up at night? \_\_\_\_\_
- 13 If you wake up, on the average, how long do you stay awake? \_\_\_\_\_
- 14 If you do awaken during the night (after you first fall asleep) which part(s) of your sleep period is it?  
( ) soon after falling asleep ( ) middle of the night ( ) early morning
- 15 What do you usually do when you awaken during the night? \_\_\_\_\_  
\_\_\_\_\_
16. What time do you usually awaken in the morning on WEEKDAYS? \_\_\_\_\_  
WEEKENDS? \_\_\_\_\_
- 17 Do you usually (Check all that apply to you.)  
( ) sleep with someone else in your bed ( ) sleep with someone else in your room  
( ) provide assistance to someone during the night (child, invalid, bed partner, animal)
18. Is your sleep often disturbed by:  
( ) heat ( ) light ( ) cold ( ) bed partner ( ) noise ( ) not being in your usual bed  
( ) other \_\_\_\_\_
- 19 Are your sleep habits on weekends different from the rest of the week?  
( ) No ( ) Yes. Please describe. \_\_\_\_\_  
\_\_\_\_\_

20 With whom are you now living? (wife, husband, children, parents, etc., please list ages) \_\_\_\_\_  
\_\_\_\_\_

21 Do you work split shifts or rotating (variable) shifts? \_\_\_\_\_  
\_\_\_\_\_

22. Do you drink coffee or tea within 2 hours before you go to bed? ( ) YES ( ) NO

23 Do you do physical exercise before bedtime? ( ) YES ( ) NO

24 Do you read before falling asleep? ( ) YES ( ) NO

25 Do you watch TV in bed before falling asleep? ( ) YES ( ) NO

26. Do you take naps during the afternoon or evening? ( ) YES ( ) NO

27 Do you feel refreshed after a 10 to 15 minute nap? ( ) YES ( ) NO

28. List your consumption of the following per day

Coffee \_\_\_\_\_ Colas \_\_\_\_\_ Tea \_\_\_\_\_  
Chocolate \_\_\_\_\_ Nicotine \_\_\_\_\_ Alcohol \_\_\_\_\_  
Non-prescription medications \_\_\_\_\_ Other drugs \_\_\_\_\_

29 List your medications below

NAME	AMOUNT	HOW OFTEN	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

30 Have you ever been knocked unconscious or had any other serious injury to your head? Please explain.

31 What is your job? If you are retired or disabled, what was your job?

32. What is your highest education level?

33 Do you smoke? If yes, for how many years have you smoked? How many packs a day?

**Directions:** For each of the items below please check either rarely or never, sometimes, or often to indicate how frequently you experienced it during the **PAST MONTH**. For those items that you checked sometimes or often, also check either mild, moderate, or severe to indicate the degree of seriousness for the item.

	FREQUENCY			SERIOUSNESS		
	Rarely or Never	Sometimes	Often	Mild	Moderate	Severe
Depression	_____	_____	_____	_____	_____	_____
Anger	_____	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____	_____
Loneliness	_____	_____	_____	_____	_____	_____
Suicidal Thoughts	_____	_____	_____	_____	_____	_____
Fears	_____	_____	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____	_____	_____
Nightmares	_____	_____	_____	_____	_____	_____
Hopelessness	_____	_____	_____	_____	_____	_____
Low Self-esteem	_____	_____	_____	_____	_____	_____

Have you attempted suicide in the last six months? ( ) YES ( ) NO

Are you contemplating causing harm to yourself at this point and time? ( ) YES ( ) NO

Have you been under the care of a mental health practitioner (e.g., psychiatrist, psychologist) in recent time's or currently? ( ) YES ( ) NO

If yes, please give name and phone number. \_\_\_\_\_

**Treatment Plan Information:** Forming a treatment plan for patients with Obstructive Sleep Apnea Syndrome requires input and cooperation between the patient and the sleep specialist. We want to correct your sleep-related breathing disorder by using the highest quality most cost effective procedures that are the least imposing to your current life style. In order to accomplish this goal, we ask that you provide us with the answers to the questions listed below Please write the treatment options listed below during your initial Sleep Disorders Center evaluation appointment. Thank you for your cooperation.

If you have a sleep study that is positive for sleep apnea syndrome, there are several treatment options available to you. Sleep apnea is a sleep-related breathing disorder where you quit breathing whenever you fall asleep. Correcting your breathing problem during sleep may involve one or more of the following treatments: (Please take time to rank them in order of your preference with 1 being the most desired treatment option)

\_\_\_\_\_ Oral Appliance – These devices work to keep the airway open by holding the tongue or jaw forward, increasing the airway space behind the tongue. They are usually fitted by an experienced dentist associated with the Sleep Disorders Center In order for the oral appliance to correct the apnea, it must be worn every time a person goes to sleep.

\_\_\_\_\_ Nasal Positive Airway Pressure Devices – These devices consist of a machine that pumps room air through a hose and into a mask that fits over the person s nose. The mask is held in place with straps. The pressure from the air blowing in the nose acts as a splint to keep the airway propped open while a person sleeps. In order for the pressure device to correct the apnea, it must be worn every time a person goes to sleep. If you feel scared, uneasy or you panic when in confined spaces such as elevators, hallways, or closed rooms, then airway pressure devices may not be the best treatment option.

\_\_\_\_\_ Surgery – An operation may be an option for correction of your apnea. There are several surgical procedures that can be performed. Some may be performed together While an operation can be an effective treatment for some patients, it is not the right choice for everyone.

Thank you for providing us with your preferred treatment options. However, please keep in mind that what you would prefer may not necessarily be what is recommended by your sleep specialist based on the findings of your sleep study

# **PATIENT NOTICE OF PRIVACY PRACTICES FOR HEALTH RELATED INFORMATION**

## **MID-SOUTH PULMONARY SPECIALISTS, P.C.**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY!**

If you consent, Mid-South Pulmonary Specialists, P.C. is permitted by federal privacy laws to make uses and disclosures of your protected health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

### **EXAMPLES OF USES OF YOUR HEALTH INFORMATION FOR TREATMENT PURPOSES ARE:**

- Nurse obtains treatment information about you and records it in a health record.
- After your appointment with the physician, the physician may call the primary-care physician to report his findings and suggestions for treatment.

### **EXAMPLE OF USE OF YOUR HEALTH INFORMATION FOR PAYMENT PURPOSES.**

- Mid-South Pulmonary Specialists, P.C. submits requests for payment to your health insurance company. The health insurance company requests information from us regarding your medical care given. We provide them with information regarding the treatment given to get paid for our services.

### **EXAMPLE OF USE OF YOUR INFORMATION FOR HEALTH CARE OPERATIONS.**

- We may obtain services from business associates such as quality improvement, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We share information about you as necessary to obtain these services.

### **YOUR HEALTH INFORMATION RIGHTS!**

The health and billing records we maintain are the physical property of Mid-South Pulmonary Specialists, P.C. You have the following rights with respect to your Protected Health Information.

- Request a restriction on certain uses and disclosures of your health information in writing to our office. We are not required to grant the request but will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by requesting one at our office.
- Right to inspect and copy your health and billing record. You may deliver the request in writing to our main location at 266 S. Cleveland, Ste 203, Memphis, TN, 38104. In the event the request for access is denied, you have the right to appeal to the Compliance Officer.
- Right to request your health care record be amended to correct incomplete or incorrect information by delivering a written request to our main office using the form provided upon request. Mid-South Pulmonary Specialists, P.C. is not required to make such amendments; you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our main office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Right to confidential communication by requesting that communication of your health information is made by alternative means or at an alternative location by delivering the request in writing to our main office using the form we provide upon request.

If you want to exercise any of the above rights, please contact the Compliance Officer, Mid-South Pulmonary Specialists, P.C. in person or in writing, during normal business hours at the main office located at 266 S. Cleveland, Ste 203, Memphis, TN, 38104; or call (901) 276-2662. The Compliance Officer will provide you with assistance on the steps to take to exercise your rights.

### **YOU HAVE THE RIGHT TO REVIEW THIS NOTICE BEFORE SIGNING THE CONSENT AUTHORIZING USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PURPOSES.**

### **MID-SOUTH PULMONARY SPECIALISTS, P.C. RESPONSIBILITIES TO OUR PATIENTS!**

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

Mid-South Pulmonary Specialists, P.C. reserves the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting our office and picking up a copy.

#### **TO REQUEST INFORMATION OR FILE A COMPLAINT**

If you have questions, need additional information, or want to report a problem regarding the handling of your information, you may contact the Compliance Officer for Mid-South Pulmonary Specialists, P.C. at (901) 276-2662.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint to our office to the Compliance Officer. You may also file a complaint by mailing it to the Secretary of Health and Human Services.

**WE CANNOT AND WILL NOT REQUIRE YOU TO WAIVE THE RIGHT TO FILE A COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHS) AS A CONDITION OF RECEIVING TREATMENT FROM THE OFFICE.**

**WE CANNOT AND WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHS).**

#### **OTHER USES AND DISCLOSURES**

**Patient Contact:** We may contact you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

**Communication with Family:** Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Required by law:** We may be required by law to report suspected abuse or neglect, or similar injuries and events.

**Public Health Activities:** As required by law, we may disclose vital statistics, diseases, or information related to recalls of

dangerous products to public health authorities, and similar information.

**Health Oversight Agencies:** We may be required to release your information to assist in investigations and audits, eligibility for government programs, and other reasons related to the administration of healthcare.

**Judicial/Administrative Proceedings:** We may disclose information in response to a subpoena, discovery request, or other lawful process.

**Law Enforcement:** We may disclose your protected health information when required by court order, or when law require reporting of wounds or other physical injury.

**Deaths:** We may report information regarding deaths to coroners, medical examiners, and funeral directors.

**Research:** We may use or disclose information for approved medical research.

**Threat to Health and Safety:** To avert a serious threat to health or safety, we may disclose you information consistent with applicable laws.

**Government Functions:** We may disclose your information as authorized by law for national security purposes, Armed Forces personnel, or public assistance program personnel.

**Workers compensation:** We may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Other Uses and Disclosures:** For any disclosure not mentioned, we will ask for your written authorization before using or disclosing any identifiable health information about you. Any authorized disclosure may be evoked for any future uses and disclosures.

**FOR ANY QUESTIONS, REQUESTS, OR COMPLAINTS PLEASE CONTACT:**

**COMPLIANCE OFFICER  
MID-SOUTH PULMONARY SPECIALISTS, P.C.  
266 S. CLEVELAND, STE 203  
MEMPHIS, TN 38104  
(901) 276-2662**

**EFFECTIVE DATE: MARCH 1, 2003**