

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, P.C.  
5050 POPLAR AVE., SUITE 800  
MEMPHIS, TN 38157

SLEEP CENTER  
PATIENT PROFILE

LAST NAME	M.I.	FIRST NAME	BIRTHDATE	SOCIAL SECURITY #
ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE #	CELL PHONE #	WORK PHONE #	NAME OF RESPONSIBLE PARTY	

**RESPONSIBLE PARTY INFORMATION**

RELATIONSHIP TO PATIENT \_\_\_\_\_

NAME: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ WORK PHONE # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

**EMERGENCY CONTACT**

\_\_\_\_\_ ( ) \_\_\_\_\_

NAME	ADDRESS	PHONE #	RELATIONSHIP TO PATIENT
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**REFERRAL INFORMATION:**

\_\_\_\_\_ ( ) \_\_\_\_\_

NAME OF REFERRING PHYSICIAN	PHONE #	RELATIONSHIP TO PATIENT
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**INSURANCE INFORMATION**

PRIMARY INS. NAME: _____	SECONDARY INS. CO _____
ADDRESS _____	ADDRESS: _____
PHONE # _____	PHONE # _____
POLICY # _____	POLICY # _____
GROUP # _____	GROUP # _____

**FINANCIAL RESPONSIBILITY/AUTORIZATION TO FILE INSURANCE.**

**THIS FORM APPLIES TO MEDICARE/MEDICAID BENEFITS, AND ANY OTHER INSURANCE BENEFITS INCLUDING SECONDARY BENEFITS.**

I AUTHORIZE MEDICAL TREATMENT AS DEEMED NECESSARY BY PHYSICIANS OF MID-SOUTH PULMONARY SPECIALISTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS CHARGED FOR SERVICES. MID-SOUTH PULMONARY DOES NOT ACCEPT RESPONSIBILITY FOR COLLECTING INSURANCE CLAIMS OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AGREE TO PAY ALL COSTS ASSOCIATED WITH COLLECTING SERVICES IN THE EVENT I FAIL TO PAY THE BALANCE DUE INCLUDING COLLECTION FEES, ATTORNEY AND COURT COSTS.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/MEDICAID AND OTHER HEALTH INSURANCE BENEFITS BE MADE ON MY BEHALF. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS AND ITS AGENTS OR MY DESIGNATED INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. 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

\_\_\_\_\_  
DATE

**Pediatric Sleep Questionnaire**  
Methodist Healthcare Sleep Disorders Center

**Child's Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Contact Information:**

**Telephone (home):** \_\_\_\_\_

**Mother's work or cell phone:** \_\_\_\_\_

**Father's work or cell phone:** \_\_\_\_\_

**Email contact (optional):** \_\_\_\_\_

**Pharmacy number (if known):** \_\_\_\_\_

**Child's Pediatrician or Primary Care Provider:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Who referred your child for a sleep evaluation?**

\_\_\_\_\_ Pediatrician or primary care provider

\_\_\_\_\_ Parent initiated referral

\_\_\_\_\_ Teacher or school nurse

\_\_\_\_\_ Pediatric specialist, such as neonatologist, allergist,  
pulmonologist, neurologist, etc.

\_\_\_\_\_ Surgical specialist, such as ENT specialist

\_\_\_\_\_ Psychiatrist or psychologist

\_\_\_\_\_ Other(specify): \_\_\_\_\_

**Please explain your concerns about your child's sleep:**

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What are your goals in coming for a sleep evaluation? \_\_\_\_\_

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**Sleep Patterns:**

What is your child's usual bed time on weeknights? \_\_\_\_\_

On weekends or holidays? \_\_\_\_\_

What is your child's usual waking time on weekdays? \_\_\_\_\_

On weekends or holidays? \_\_\_\_\_

How long does it take your child to fall asleep? \_\_\_\_\_

How many times does your child awaken after falling asleep? \_\_\_\_\_

Where does your child typically fall asleep? \_\_\_\_\_

Where does he/she typically wake up? \_\_\_\_\_

Are parents or others present as the child falls asleep? \_\_\_\_\_

How many naps does your child take, and what time(s) do they occur? \_\_\_\_\_

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**Does your child experience:** (Mark yes or no)

Yes    No

- \_\_\_\_    \_\_\_\_ Difficulty falling asleep?
- \_\_\_\_    \_\_\_\_ Difficulty staying asleep?
- \_\_\_\_    \_\_\_\_ Difficulty waking up in the morning?
- \_\_\_\_    \_\_\_\_ Nightmares or sudden awakenings from sleep?
- \_\_\_\_    \_\_\_\_ Snoring during sleep?
- \_\_\_\_    \_\_\_\_ Gasping or snorting during sleep?
- \_\_\_\_    \_\_\_\_ Breathing problems during sleep?
- \_\_\_\_    \_\_\_\_ Periods of cessation of breathing during sleep?
- \_\_\_\_    \_\_\_\_ Difficulty sleeping unless propped up on multiple pillows?
- \_\_\_\_    \_\_\_\_ Excessive jerks or twitches during sleep?
- \_\_\_\_    \_\_\_\_ Restless sleep?
- \_\_\_\_    \_\_\_\_ Kicks legs repetitively during sleep?
- \_\_\_\_    \_\_\_\_ Uncomfortable feelings or pain in legs (creepy crawly feelings)?
- \_\_\_\_    \_\_\_\_ Talking during sleep?
- \_\_\_\_    \_\_\_\_ Walking or running during sleep?
- \_\_\_\_    \_\_\_\_ Bedwetting? If so, how often per week? \_\_\_\_\_
- \_\_\_\_    \_\_\_\_ Frequent or persistent nasal congestion or sinus problems?
- \_\_\_\_    \_\_\_\_ Teeth grinding during sleep (bruxism)?
- \_\_\_\_    \_\_\_\_ Excessive daytime sleepiness, such as falling asleep in school?
- \_\_\_\_    \_\_\_\_ Naps after school?
- \_\_\_\_    \_\_\_\_ Irritability moodiness or sudden changes in emotions?
- \_\_\_\_    \_\_\_\_ Drink caffeinated beverages? How many per day? \_\_\_\_\_

Has your child had a previous sleep evaluation or sleep study (explain when and where)?

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Has your child ever had:

- \_\_\_\_\_ Tonsillectomy (give date if known) \_\_\_\_\_
- \_\_\_\_\_ Adenoidectomy (give date if known) \_\_\_\_\_
- \_\_\_\_\_ Ear tube placement (give date if known) \_\_\_\_\_
- \_\_\_\_\_ Broken nose or other nasal trauma (give date if known) \_\_\_\_\_
- \_\_\_\_\_ Enlarged tonsils or adenoids but no surgery \_\_\_\_\_

**Past Medical History**

Birth weight: \_\_\_\_\_

Was your child born prematurely? \_\_\_\_\_

If so, what was the gestational age? \_\_\_\_\_

Were there complications during pregnancy labor or delivery(explain)? \_\_\_\_\_

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Is your child, or has your child ever been on a home apnea monitor? \_\_\_\_\_

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If yes, what are the current settings for apnea delay? \_\_\_\_\_

Heart rate? \_\_\_\_\_

Is your child, or has your child ever been treated with nasal CPAP? \_\_\_\_\_

If yes, what pressure was used? \_\_\_\_\_

Does your child have any allergies to medications (explain)? \_\_\_\_\_

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What medications is your child receiving on a routine basis?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

“As needed medications” \_\_\_\_\_

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**Does your child have a history of:**

(check those that apply)

- Recurrent headaches
- Vision problems
- Hearing problems
- Learning disabilities
- Inattentiveness or easy distractability
- Hyperactivity
- Attention Deficit Hyperactivity Disorder (ADHD)
- A genetic disorder that affects development such as Down syndrome, Prader Willi syndrome, Fragile X syndrome (specify): \_\_\_\_\_
- Epilepsy (recurrent seizures)
- History of head trauma
- History of meningitis
- Developmental delay
- Cerebral palsy
- Autism or Autistic Spectrum Disorder (Asperberger's syndrome, PDD, etc.)
- Mental retardation
- Asthma (reactive airways disease)
- Gastroesophageal reflux (GER)
- Recurrent ear or throat infections
- Poor weight gain or failure to thrive
- Overweight or obesity
- Heart disease (specify): \_\_\_\_\_
- High blood pressure
- Sickle cell disease or other blood problems
- Chronic pain syndrome such as arthritis, fibromyalgia, neck or back pain, or diffuse muscle aches
- Anxiety or panic attacks
- Depression or possible depression
- Obsessive/compulsive problems
- Behavior problems such as oppositional/defiant behaviors
- Psychological trauma such as recent loss of loved one, divorce or separation, exposure to violence, abuse or neglect (specify): \_\_\_\_\_

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- For adolescents, history of alcohol or substance abuse
- Other medical or psychological problems (specify): \_\_\_\_\_

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**Educational History**

Current grade: \_\_\_\_\_ School: \_\_\_\_\_

Typical grades: \_\_\_\_\_

Does your child receive any special services at school? \_\_\_\_\_

Does your child have excessive absences or tardy days? \_\_\_\_\_

Has your child experienced areas of academic challenge or failure? \_\_\_\_\_

\_\_\_\_\_

**Family History**

Name(s) Age Sleep Problems or Disorders?

Parents:

\_\_\_\_\_  
\_\_\_\_\_

Brothers/Sisters:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Grandparents:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child being followed by a:

- \_\_\_\_\_ Pulmonologist?
- \_\_\_\_\_ Neurologist or child neurologist?
- \_\_\_\_\_ Psychiatrist or child psychiatrist?
- \_\_\_\_\_ Psychologist?
- \_\_\_\_\_ Ear, Nose and Throat (ENT) specialist?
- \_\_\_\_\_ Other specialist(s)? Specify \_\_\_\_\_



# **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**