The Insomnia and Sleep Institute of Arizona

8330 E Hartford Drive, Suite 100, Scottsdale, AZ 85255
1530 E Williams Field Road, Suite 204, Gilbert, AZ 85295
Phone: 480-745-3547 / Fax: 480-745-3548
www.sleeplessinarizona.com

PATIENT INFORMATION

Patient Full Name:_____ Date:_____/_____/_____

Address: _____

Home Phone:_____- _____- _____ Mobile Phone: _____- _____-_____

Marital Status: ❑Married ❑Single ❑Divorce ❑ Widow ❑ Other Email Address:_____

Sex: ____ Age: ____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian ❑ Black or African American ❑ White
❑ Hispanic ❑ Other Race ❑ Other Pacific Islander ❑ Refused to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refused to Report

Language: ❑ English ❑ Indian (Hindi/Tamil) ❑ Spanish ❑ Russian ❑ Other

Employer Name: _____

Employer Address: _____

Business Phone: _____- _____- _____ Occupation: _____

Spouse Name: _____

Who should be notified in case of emergency? _____

Phone #: _____- _____-_____

Referring Physicians Name: _____ Primary Care Physician: _____

Address: _____ Address: _____

City: _____State: _____ Zip:_____ City: _____State: _____Zip: _____

Phone #: _____- _____- _____ Phone #: _____- _____-_____

Fax #: _____- _____- _____ Fax #: _____-_____-_____

INSURANCE INFORMATION *(MUST BE COMPLETED)*

PRIMARY INSURANCE NAME: _____

Address: _____ Phone #:_____

Policy #: _____ Group #:_____

Policy Holder Information *(if different)*

Policy Holder Name: _____Policy Holder Phone:_____

Policy Holder SS #: _____Policy Holder DOB: _____/_____/_____

SECONDARY INSURANCE NAME: _____

Address: _____ Phone #:_____

Policy #: _____ Group #:_____

Policy Holder Information *(if different)*

Policy Holder Name: _____Policy Holder Phone:_____

Policy Holder SS #: _____Policy Holder DOB: _____/_____/_____

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EMAIL & PATIENT PORTAL OPT-IN AGREEMENT

Email Opt-In

Dear Patient – We will be implementing a follow-up and appointment reminder system that will send an email to you with information regarding your office visit. Studies show that more than 70% of patients say reminders help them remember an appointment. Check the box below to *Opt-In* and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anyone. You may choose to *Opt-Out* at any time.

☐ I would like to receive email correspondence for appointment follow-ups, reminders, or patient education information.
☐ I would **NOT** like to receive email correspondence for appointment follow-ups, reminders, or patient education information.

Patient Portal Opt-In

We are implementing a patient portal on our website that will allow for easier communication between you and The Institute. This patient portal will eventually allow for setting up appointments, requesting medication refills, and accessing your medical records. Check the box below to Opt-*In* and indicate that you would like to be included in this program. Your information is strictly to help us provide better quality care and is not shared with anyone. You may choose to *Opt-Out* at any time.

☐ I would like to be setup with patient portal access.
☐ I would **NOT** like to be setup with patient portal access.

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

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: 1) Conduct plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment direct and indirectly. 2) Obtain payment from third-party payers. 3) Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used to disclose and carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree, then you are bound to abide by such restrictions.

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

CONSENT FOR VIDEO TAPING

As part of a diagnostic sleep study, necessary videography is performed during the study to monitor for unusual behaviors during sleep such as seizure-type activity, sleep talking, sleep terrors, sleep walking, dream enactment behaviors, leg kicking, and/or any other unusual behaviors that will need to be reviewed by the physician to make an accurate analysis of your study. All information and data will be kept confidential and after review of the study by the physician, the video is archived and never shared with any party. I hereby authorize the use of videography for the purpose of medical diagnosis only. If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

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

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PURVEYOR OF GOOD DREAMS

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PATIENT HISTORY

Patient: _____ **Date:** _____

Occupation: _____ **Height:** _____

Weight: Now: _____ One Year Ago: _____ Maximum: _____

Describe the main reason for your office visit or test with us:

FAMILY HISTORY:

Number of Siblings: _____ Brothers: _____ Sisters: _____

	FATHER	MOTHER	BROTHERS	SISTERS
Living (L) or Deceased (D)				
Age (if living; or at time of death)				
Health (good or bad)				
Sleep Walking				
Snoring				
Sleep Apnea				
Insomnia				
Migraine				
High Blood Pressure				
Cause of death (if deceased)				
Other inherited conditions				

PERSONAL HISTORY:	YES	NO
Married (YRS)		
Children (#)		
Rheumatic Fever, Heart Disease		
Arthritis; Rheumatism		
Bone or Joint Disease		
High Blood Pressure		
Atrial Fibrillation		
Cardiac Pacemaker or Defibrillator		
Cancer		
High Cholesterol		
Diabetes		
Glaucoma		
Anemia; Jaundice		
Epilepsy, Seizures		
Migraine Headache		
Asthma		
Broken Bones		
Head Injury		
Skin Rashes		
Abnormal Heart Rhythm		

ALLERGIES:	YES	NO
Penicillin		
Sulfa		
Aspirin		
Codeine, Morphine		
Mycins or Antibiotics		
Other Drug		
Food Allergies		
Pollen Allergies		

SURGERIES:	YES	NO
Tonsils, Appendix		
Gallbladder		
Disc, Pinched Nerve		
Weight Loss Surgery		
Hysterectomy		
Other Surgery (name)		
Other Hospitalization		

Have you ever had a Polysomnogram (sleep test)? If yes; then fill out the table below

DATE	FACILITY	RESULT

Please describe if you have had the following tests in the past year:

TEST	DATE	RESULT
Chest X-Ray		
EKG (Cardiogram)		
EEG (Brainwave Test)		

MEDICATIONS: (Prescription and over the counter drugs)

SERIAL #	NAME	DOSAGE	TIMING	REASON FOR MEDICATION
1				
2				
3				
4				
5				
6				
7				
8				

PERSONAL HABITS:

	REGULAR / OCCASIONAL	QUANTITY	COMMENTS
Regular Coffee			
Caffeinated Drinks			
Tobacco Products			
Chocolates			
Alcoholic Beverages			

SYSTEM REVIEW:

	YES	NO
Eye Disease or Injury		
Vision Loss (Temporary / Permanent)		
Ear Disease or Injury		
Fainting Spells		
Numbness, Part of the Body		
Headaches (Frequent or Severe)		
Change in Appetite		

	YES	NO
Chest Pain		
Shortness of Breath		
Palliations, Heart Flutter		
Kidney Disease		
Trouble Urinating		
Stomach Ulcer		
Liver Disease		

WOMEN ONLY:

Menstrual Periods: Regular _____ Irregular _____ Problems associated with periods: _____

Please describe any additional information below:

_____

_____

Please answer all of the following questions as completely and accurately as possible because it will help in your correct diagnosis and treatment of your sleep related problems.

What year was your last physician exam? _____

Physician's_Name: _____

Physician's_Address: _____

Physician's Phone Number: _____

Brief results of exam: _____

Do you exercise adequately? _____ How? _____

GENERAL SLEEP INFORMATION:

1. How long have you had a sleep problem? _____
2. How many nights in a week do you have sleep problems? _____
3. What time do you usually go to bed? _____
4. What time do you leave bed to start the regular day routine? _____
5. Are you usually refreshed when you get out of bed? _____
6. How many hours do you sleep on an average night? _____
7. How many times are you awake during an average night? _____
8. How long altogether are you awake after you first fall asleep? _____
9. On average, how many days each week do you nap? _____
10. What time? _____ Length of Nap? _____
11. Do you have problems with nightmares? ☐ Yes ☐ No
12. Do you have difficulty getting to sleep? ☐ Yes ☐ No
13. How long does it usually take you to fall asleep? _____
14. Do you feel unable to relax? ☐ Yes ☐ No
15. Do your thoughts race? ☐ Yes ☐ No
16. Do you have restlessness in your legs as you fall asleep? ☐ Yes ☐ No
17. Do you have twitching in your legs as you fall asleep? ☐ Yes ☐ No
18. Do you have any unusual sleep behavior? ☐ Yes ☐ No
19. Does your sleeping partner find any unusual sleep behavior during your sleep? ☐ Yes ☐ No

If yes, please describe: _____

Check which of the following techniques you use to help fall asleep:

❑ Medication ❑ Biofeedback ❑ Hypnosis ❑ Relaxation techniques ❑ Baths, Hot Tubs, Etc.
❑ Exercise ❑ Special Diet, Drinks ❑ Vitamins, Herbal Products ❑ Mental Imagery (counting sheep, etc.)

For questions below, please circle the number by the following grading system:

1	2	3	4	5
No Problem Never Occurs	**Mild Problem Rarely Occurs**	**Moderate Problem, Happens Occasionally**	**Moderately Severe Problem Occurs Frequently**	**Severe Problem Occurs Very Frequently**

HOW OFTEN IS YOUR SLEEP DISTRUBED DURING THE NIGHT OR AT SLEEP ONSET BECASUSE OF:

1. Heat, cold, light, noise, or other bedroom conditions? 0
2. Asthma? 0
3. Shortness of breath while lying flat? 0

HOW OFTEN DO YOU?

1. Usually get up to urinate during the night? 0
2. Have nasal congestion, stuffiness, or blockages during the night? 0
3. Snore in any way during sleep? 0
4. Snore loudly and disruptively? 0
5. Hold your breath or stop breathing during sleep? 0
6. Wake up gasping for breath or feeling unable to breathe? 0

DURING THE DAY, HOW MUCH DIFFICULTY HAVE YOU HAD?

1. Daytime hallucinations or dreaming? 0
2. Sleep paralysis or not being able to move when first waking up? 0
3. With sudden weakness if you are surprised, upset, or laughing hard? 0

Check One Statement: Which best describes your sleep during the day?

_____ I have no unwanted sleepiness or involuntary sleep episodes.

_____ Unwanted sleepiness or involuntary sleep episodes occur during activities that require little attention. Examples include sleepiness that is likely to occur while watching television, reading, or traveling as a passenger. Symptoms produce only minor impairment of social or occupational function.

_____ Unwanted sleepiness or involuntary sleep episodes

MENTAL HEALTH:

Check any of the following that apply to you:

❑ Nightmares ❑ Ideas of Suicide ❑ Difficulty with Decisions ❑ Poor Memory ❑ Feel Tense
❑ Unable to Relax ❑ Depression ❑ Poor Concentration ❑ Feel Panicky

Do you now see a psychiatrist or a mental health worker *(If yes, please describe)*: _____

_____

Have you ever been treated for alcoholism or drug abuse? *(If yes, please describe)*: _____

_____

Please add any other information about your sleep problem that you feel may be important: _____

_____

PLEASE COMPLETE THIS SECTION IF YOU HAVE BEEN DIAGNOSED WITH OR TREATED FOR SLEEP APNEA:

What year was your sleep apnea diagnosed? _____
What year was your last overnight sleep test? _____

Have you ever had surgery for sleep apnea? ❑ Yes ❑ No
What year was your sleep apnea surgery? _____
Please describe the type of surgery: _____

Have you ever used CPAP? ❑ Yes ❑ No
What year was your CPAP first prescribed?
Do you use CPAP now? _____
How many nights each week? _____
How many hours each week? _____
Please describe any problem you have, or had, with CPAP: _____

Have you ever used a dental appliance for sleep apnea? ❑ Yes ❑ No
What year was the appliance first prescribed? _____
Do you use the appliance regularly now? ❑ Yes ❑ No
If you had problem(s), please describe: _____

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

EPWORTH SLEEPINESS SCALE

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Patient Name:_____ DOB:_____ Date:_____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't 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
Sitting and reading	0
Watching TV	0
Sitting, inactive in a public place (i.e.- a theatre or a meeting)	0
As a passenger in a car for an hour without a break	0
Lying down to rest in the afternoon when circumstances permit	0
Sitting and talking with someone	0
Sitting quietly after a lunch without alcohol	0
In a car, while stopped for a few minutes in traffic	0
Total (add each number from the 8 situations above)	_____

A score > 8 is indicative of pathological daytime sleepiness.
A score < 8 is indicative of normal level of daytime alertness.

IMPORTANT INFORMATION FOR SLEEP STUDY PREPARATION

A fee of $200 will be charged for cancellations or changes within 72 hours of an appointment not payable by your insurance

- ❑ Please note the instructions for entry into The Institute facilities:

  FOR SCOTTSDALE: To the right of the main entrance there is an intercom/camera mounted to the wall. Press the intercom and your technician will buzz you in through the main doors.

  FOR GILBERT: To the right of the elevator on the 2nd floor, there is a corridor on the left with bathrooms; there is a door at the end of this hall that is the entrance for your sleep study. Press the intercom and your technician will come greet you at the door.

  FOR PROBLEMS WITH ENTRY INTO THE FACILITY – CALL 480-745-3547 ext 5

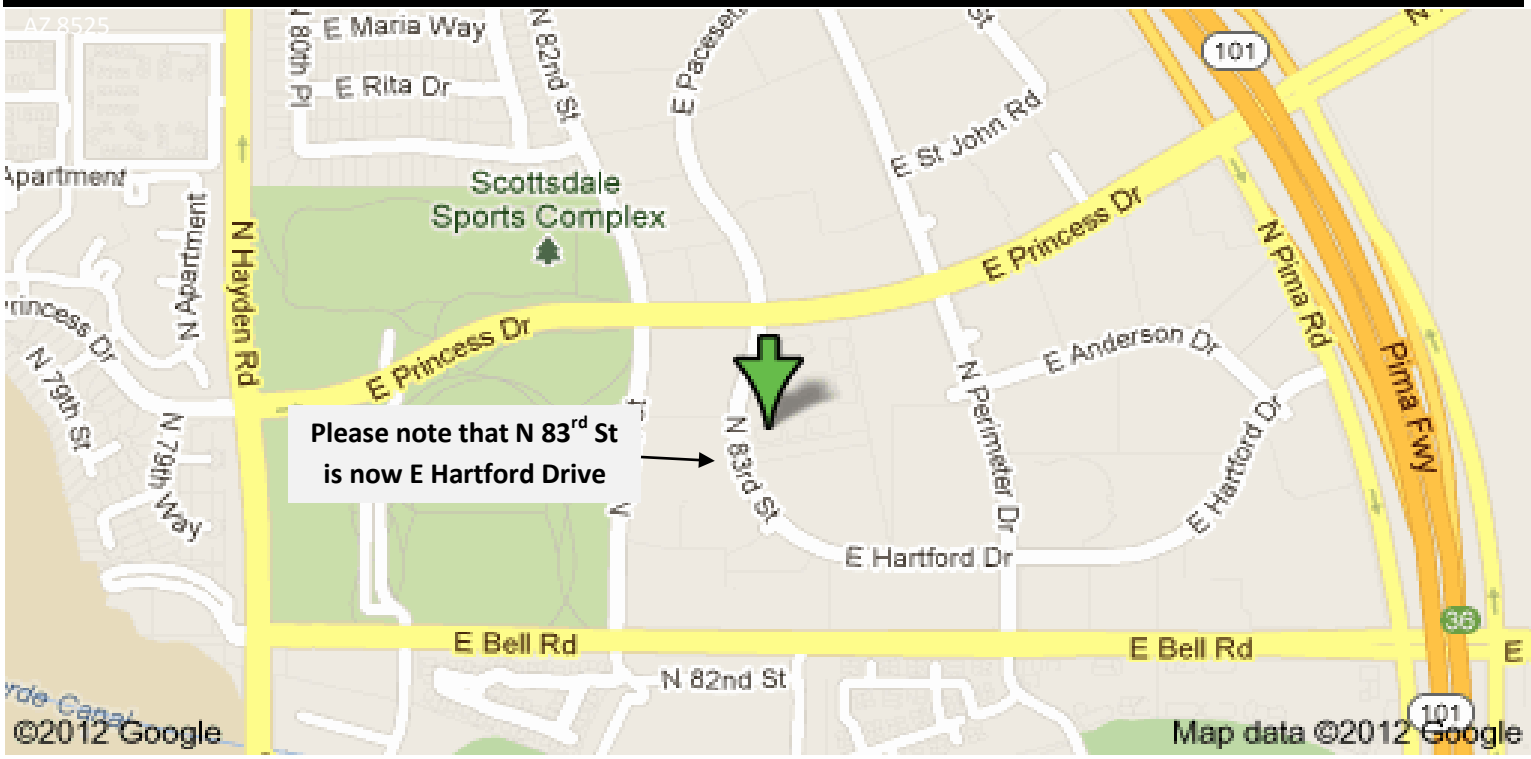
- ❑ Arrive to the sleep lab between 7:30 p.m. – 8:30 p.m. on the night of your study. If you need to arrive later please notify us in advance so that your sleep technician is aware.
- ❑ Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply makeup, nail polish, face or body cream/lotion, as they may interfere with electric sensors.
- ❑ Take all your regular medications, unless instructed by your physician to do otherwise. Keep a record of your medications and the time taken. **Please bring any medication that you may need to take with you during your stay.**
- ❑ Please do **NOT** consume beverages or food containing caffeine after 12:00 p.m. on the day of the study.
- ❑ Try to get a full night of sleep the night prior to your study. Please do **NOT** take any naps the day of your study.
- ❑ Please bring nightclothes for the study. Loose fitting, cotton pajamas are preferred. Please avoid nightclothes that are made of satin, nylon, or silk because the chemicals/pastes could damage them.
- ❑ Feel free to bring personal belongings to your study that may help your sleep more comfortably, e.g., favorite pillow, blanket, book, etc.
- ❑ Bathrooms with shower stalls are available for your convenience. You may choose to bring a toothbrush, toothpaste, shampoo and soap for the morning to freshen up. In addition, you may have to wash your hair several times to remove the paste from your hair used during the study.
- ❑ You are usually free to leave by 6:00-6:15 am the following morning unless otherwise specified based upon your usual wake time.

SPECIAL INSTRUCTIONS FOR MULTIPLE SLEEP LATENCY (MSLT) TEST

1. The MSLT is performed the morning after an all-night sleep study ONLY for patients that are being investigated for narcolepsy.
2. Granola/Cereal bars and water are provided in the morning during this test. Please bring lunch with you, as well as any non-caffeinated, non-alcoholic beverages for use during the day.
3. Please bring reading materials to read during your stay with us**.** You may also bring a laptop for your use.
4. The urine toxicology test will be performed during the day of your study. Your insurance will be billed directly from the Laboratory (Labcorp or Sonora Quest) performing the test; if you know which lab your sample must go to because of insurance reasons please notify us in advance otherwise your sample will be sent to LabCorp.
5. The testing is usually concluded between 4:00-5:00 pm.

Additional questions in preparation for your sleep study – please contact the Director of Sleep Diagnostic Services at 480-745-3547.

SCOTTSDALE MAP



From the East

Loop 202 West to
Loop 101 North
Take the Princess Dr. Exit, EXIT 36.
Turn left onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

8330 E HARTFORD DR is on the left.

From North Phoenix/Glendale/Sun City

101 South:
Take the Princess Dr. Exit, EXIT 36
Turn right onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

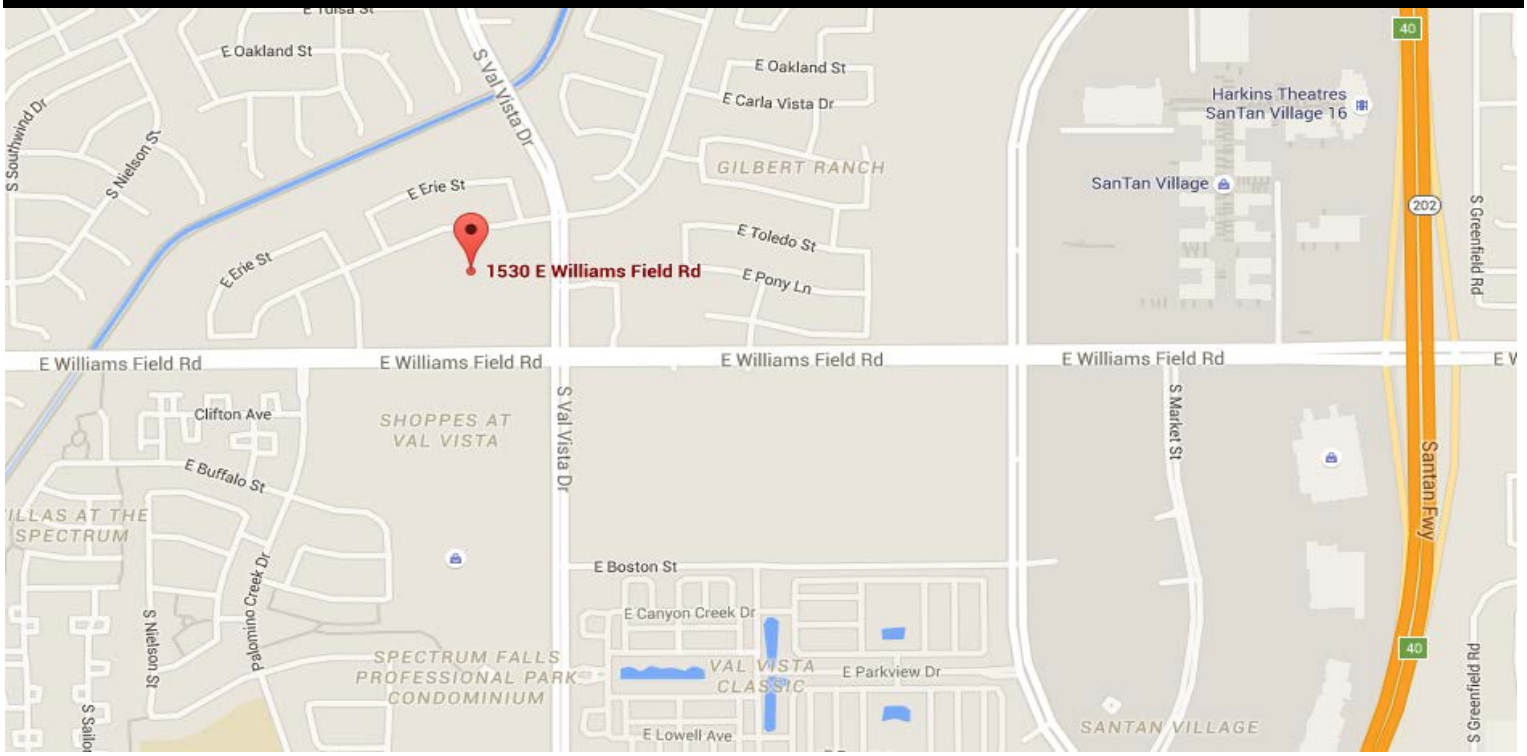
8330 E HARTFORD DR is on the left.

From Downtown Phoenix

51 North to
Loop 101 East
Take the Princess Dr. Exit, EXIT 36.
Turn right onto E Princess Dr.
Turn left onto E Hartford Dr.
E Hartford Dr. is 0.1 miles past N Perimeter Dr.
If you reach N 82nd St you've gone a little too far

8330 E HARTFORD DR is on the left

GILBERT MAP



From the East

Loop 202
Take Val Vista Drive Exit, Exit 42
Go North on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Drive and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

OR

Take E Williams Field Road Exit, Exit 43
Go West on E Williams Field Road to Val Vista Drive
Turn right into The Forum at Gilbert Ranch (just east of the intersection) / Building 1530 will be 2nd building on your right

PLEASE NOTE THERE IS AN ELEVATOR ON THE GROUND FLOOR OF BUILDING 1530 THAT CAN TAKE YOU TO THE 2ND FLOOR. ACCESS IS THROUGH THE DOOR MARKED WITH "ELEVATOR"

From the West

Loop 101 South to Loop 202 East
Take Val Vista Drive Exit, Exit 42
Go North on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Dr and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

OR

Loop 101 South to US 60 East
Take the Val Vista Drive Exit, Exit 184
Go South on Val Vista Drive
Turn left into The Forum at Gilbert Ranch (just north of the intersection) on the NW corner of Val Vista Drive and E Williams Field Road
Building 1530 will be the 2nd building on your right and suite 204 is at the top of the stairs

PLEASE NOTE THERE IS AN ELEVATOR ON THE GROUND FLOOR OF BUILDING 1530 THAT CAN TAKE YOU TO THE 2ND FLOOR. ACCESS IS THROUGH THE DOOR MARKED WITH "ELEVATOR"

PATIENT INFORMATION

Welcome to our practice. We hope that your relationship with Dr. Patel and the staff at The Institute will be a longstanding relationship that is mutually beneficial. The Insomnia and Sleep Institute of Arizona is a practice that has special knowledge and training in the area of Sleep Disorders Medicine. We appreciate your confidence in our practice and would like to provide the following information in an effort to facilitate a positive doctor-patient relationship.

APPOINTMENTS: Office schedules do not allow for "drop in" appointment times. Please call and make an appointment with the medical receptionist so that you can address your concerns with Dr. Patel during a formal office visit.

We try to avoid prolonged wait times for our patients by allotting enough time for each patient to interact with their doctor. While we cannot always anticipate patient's problems, we try to avoid situations that delay your visit with your physician. Please let our office staff know if you are experiencing an excessive wait time. Please show our practice the same courtesy by arriving at least 10 minutes early for your appointment. Late patients will usually be rescheduled as we do not believe it is fair practice to force a patient that has arrived early / on time for his or her appointment to have to make accommodations for late arriving patients.

NO SHOW AND APPOINTMENT CANCELLATIONS: We appreciate the courtesy of your call in the event you are not able to keep your appointment so that we may schedule another patient during that time. A minimum of 72 hours is required for appointment cancellations for a sleep study and 24 hours for an office visit; there will be a charge of $200 for a sleep study appointment and $75 for an office visit. We reserve the right to terminate our relationship with patients who habitually do not keep their appointments.

TELEPHONE CALLS: Our telephone and voicemail system are necessary to handle the volume of phone calls to our office. Please listen to the options carefully and choose the one that best suits your needs. Most commonly used choices are *Receptionist and appointment scheduling* (option 1), *Billing* (option 3), *Medication or CPAP supply refills* (option 4), *Questions regarding your upcoming sleep study or questions regarding your CPAP* (option 5), and *For contact information, hours, and location* (option 6). We will make every effort to return your call in an expedient manner. The more information you can share in your message, the quicker and easier it will be to respond appropriately to your call. Our receptionists do not have the medical knowledge to make suggestions regarding your healthcare. Please do not share medical information with them but instead leave a message on the medical assistant's voicemail.

PRESCRIPTION REFILLS: Please obtain prescriptions from your doctor at a scheduled office visit. However, if you need a refill, your need can be more easily met if you contact your pharmacist and have them call or fax us a refill request. Refill requests will be handled within 24 hours unless there is a problem and we notify you otherwise. Always check with your pharmacy first before calling the office. PLEASE do not wait until you are completely out of medication before calling your pharmacy. **Any refill request placed on Friday afternoon WILL NOT BE MADE until Monday morning. If the refill request is made for Ambien, Lunesta, Clonazepam, Ritalin, Adderall, Nuvigil, etc., these must be printed and signed by the physician. These must be placed 72 hours before you would like to collect them. These scripts WILL NOT BE MAILED/FAXED/EMAILED and they must be collected in person.** Refill requests should be handled during regular office hours. Our physician will not authorize refill requests on nights or weekends.

SLEEP STUDY RESULTS: The results should be available within a reasonable amount of time after completing your sleep study. Sleep study results will be discussed during your follow-up appointment with Dr. Patel. They will not be given out over the phone and or via e-mail.

COMPLETION OF FORMS: As a result of the amount of time that it takes to complete the various forms that are needed for FMLA, family medical leave, etc., there will be a charge of $25 per request for the completion of these forms.

PRINTING/COPYING: The initial 50 pages will be free for printing or copying your medical records but after 50 pages each subsequent page will be $0.10 / page.

EMERGENCIES OR ILLNESS AFTER HOURS: If you are having a medical emergency please contact 911.

INSURANCE, DISABILITY and MEDICAL RECORDS: There are increasing numbers of forms that are requested to document disability and/or insurance benefits eligibility. Various documents request an enormous amount of information. Our policy is to provide adequate medical information pertinent to your request and must be accompanied by an authorization to release medical information. Additionally there will be a charge of $25 for all form completion. Should you need a copy of your medical records, an authorization to release medical records should be completed. Please allow 2 weeks for completion of forms.

HIPAA: Our office adheres to all mandates under the current HIPAA (Health Information Portability and Accountability Act). Please ask to speak with our HIPAA Compliance Officer if you have any questions regarding this act and your privacy issues.

I have read the above patient information and a have a full understanding of all of the items discussed.

Patient's Name: _____

Responsible Party (If not the Patient): _____

_____ _____
Signature of Patient or Responsible Party Date

For questions or concerns, please contact Keleigh Fowler, Office Administrator at 480-745-3547, ext. 3.

FINANCIAL POLICY: You are financially responsible for the medical services you receive. Please review our policies below and sign at the end to indicate your agreement to these terms.

INSURANCE PLAN PARTICIPATION: We participate in many but not all insurance plans. It is your responsibility to contact your insurance company and verify that your assigned physician participates in your plan. Out of network charges may have higher deductibles and copayments.

PROOF OF INSURANCE: All patients must keep on file current insurance cards. At your initial visit we will also require a copy of your driver's license. If you are not insured by a plan that we participate with, payment in full is expected at each time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card(s).

UPDATED CHANGE OF INFORMATION & COVERAGE: We will ask you to update this whenever you have a change of address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

COPAYMENTS, DEDUCTIBLES & CO-INSURANCE: All co-payments, deductibles & co-insurance must be paid at the time of services. Payment of your co-payment, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered an act of fraud by your insurance plan.

PROCEDURE PREPAYMENT: We collect your payment for a procedure prior to the procedure taking place. Your prepayment is based on an estimate of your expected financial responsibility. This is an estimate only. You are responsible for any unpaid balance after your insurance (if applicable) has been billed. In the event of overpayment you may request a refund according to our refund policy below. We reserve the right to reschedule your procedure until prepayment has been made.

NON-COVERED SERVICES: Please be aware that some or perhaps all of the services you receive may not be covered by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.

REFERRALS: Some insurance plans require a referral from a primary care physician to obtain services from a specialist. Your insurance carrier may have stipulations regarding the type of referral such as paper, verbal or through the insurance company's website. These plans will not pay for services without the proper type of referral. It is **YOUR** responsibility to obtain a referral prior to your visit. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.

AUTHORIZATIONS: Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at the time meets medical necessity for the services and not a guarantee of payment. Your insurance company will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be

rendered until a claim is submitted.

INSURANCE BENEFITS: We will contact your insurance company to obtain benefits for you. However please be aware that the information supplied by your insurance is only "quote of benefits" and may not be honored by your insurance company. The quote of benefits is subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of your health benefit plan at the time services are rendered. The payment decision will not be made until after the claim is submitted.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

SELF-PAY: If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service unless you make other arrangements with our billing department. The current self-pay fee schedule is available from our front desk.

NON-PAYMENT: If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and made arrangements. If the account remains unpaid, we will turn your account over to a collection agency after the 90th day past due. You agree to pay for any expenses we incur to collect on your account, including reasonable attorneys' fees and collection costs.

REASSIGNMENT OF BALANCES: If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.

PAYMENT METHODS: We accept cash, personal checks, money orders, cashier's checks, MasterCard, Visa, Discover and American Express as payment for services rendered.

RETURNED CHECKS: A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the first occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.

REFUNDS: Refunds for overpayment or prepayment on cancelled procedures are made only after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: The Insomnia & Sleep Institute of Arizona, ATTN: Billing Department, 8330 E Hartford Drive, Suite 100, Scottsdale, AZ 85255-7205.

This is an agreement between The Insomnia & Sleep Institute of Arizona and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

Patient's Name: _____

Responsible Party (If not the Patient): _____

_____ _____

Signature of Patient or Responsible Party Date

For questions or concerns, please contact Keleigh Fowler, Office Administrator, at 480-745-3547, ext. 3.