Overlake Internal Medicine Associates
OVERLAKE SLEEP DISORDERS CENTER
1100 112th Avenue NE, Suite 320 Bellevue, WA 98004
Phone (425) 289-3000 Fax (425) 289-3240

Date _____

Dear _____,

Thank you for choosing Overlake Sleep Disorders Center for your care. We look forward to seeing you on _____, at _____a.m/p.m. Please complete the attached documents and bring them with you to your appointment. Directions to the Overlake Sleep Disorders Center are also attached.

Thank you,

Overlake Sleep Disorders Center Staff

OSDC
Overlake Sleep Disorders Center

Scott Bonvallet, M.D., FCCP **Randip Singh, M.D.**

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24-HOUR CANCELLATION POLICY

Due to the nature of overnight sleep studies, it is necessary to make individual reservations for sleep studies. The following policy assures our ability to maintain availability of therapy, appropriate staffing, and timely service.

- For daytime appointments, please arrive fifteen minutes early to register and fill out paperwork.
- If you are more than 10 minutes late for any appointment, you may be asked to reschedule your appointment.
- If you must cancel or change your appointment for any reason, please do so at least **24-hours** in advance of your scheduled arrival time.
- For day time appointments, there will be a non-refundable **seventy five dollar ($75.00)** charge for cancelling an appointment less than 24 hours in advance or failing to show without notice.
- For overnight appointments, there will be a non-refundable **two hundred-fifty dollar ($250.00)** charge if you miss your appointment without a **24-hour** notice.
- As a courtesy, we will attempt to confirm your appointment by telephone two to three days prior to your appointment. If we are unable to do so, please feel free to call to confirm your appointment at (425) 289-3000.

Please contact Overlake Sleep Disorders Center at (425) 289-3000 with any questions or concerns regarding appointments. Business hours are Monday – Friday, 7:30 a.m. - 5:00 p.m.

Thank you for your cooperation,

Overlake Sleep Disorders Center

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Overlake Sleep Disorders Center

Account #: _____

Legal Name: _____
(First) (Middle) (Last)

Date of Birth:_____ Sex: Male____ Female_____ Social Security # (Optional):_____

Address:_____
(Street) (Apt./Unit#) (City) (State) (Zip)

Home #: _____ Work #: _____ Cell #: _____

Neck Size:_____ Are you a shift worker? Yes_____ No_____ Shift Hours: _____

Allergies: _____ Email: _____

Marital Status: _____ Name of Spouse: _____ Spouse's Contact Phone #: _____

Employer : _____

Address: _____
(Street) (Suite) (City) (State) (Zip)

Occupation: _____ Years @ your job: _____ If retired as of what date? _____

Emergency Contact Name: _____ Relationship: _____

Contact Phone #: _____

Physician Information

Referral Source: Physician / Family / Friend / Other _____

Referring Physician: _____/ Phone#:_____

Regular / Primary Physician: _____/ Phone #: _____

Insurance Information

Primary Insurance: _____

Policy Holder's Name: _____ Birth date: _____

ID #: _____ Group #: _____

Your relation to Policy Holder:_____ Co-pay: _____

Secondary Insurance: _____

Policy Holder's Name: _____ Birth date: _____

ID #: _____ Group #: _____

Your relation to Policy Holder:_____ Co-pay: _____

The above information is true to the best on my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made with this office, in advance. I authorize the physicians and Overlake Internal Medical Associates to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Signature:_____ **Date:** _____

PATIENT NAME	Date of Birth	ACCOUNT NUMBER

CONSENT TO CARE AND FINANCIAL RESPONSIBILITY

MEDICAL TREATMENT: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Sleep Center and its employees, and all other persons caring for me to provide treatment and care as may be deemed necessary and available to me during my stay in the Sleep Center including, but not limited to tests, examinations and medical treatment. I understand that my care is under the control of my attending physicians who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination at the Overlake Sleep Disorders Center.

PHOTOGRAPHS: The taking, reproduction and use of photographs will be done in connection with my diagnosis, care and treatment at Overlake Sleep Disorders Center. Photographs include the use of video and television monitoring by the technical staff and physicians.

OBSERVATIONS: For the purpose of advancing medical knowledge and training, I consent to the presence of observers during tests, examinations and other procedures.

RELEASE OF INFORMATION: I hereby authorize Overlake Sleep Disorders Center to disclose all or any part of my record, and any other information in the Center's possession, to any other person or entity which is or may be liable for all or part of the charges related to my care, including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release Overlake Sleep Disorders Center from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Overlake Sleep Disorders Center to furnish requested information excerpts from my record to any insurer, it intermediary or another health care facility to provide continuity of care. Overlake Sleep Disorder center may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Overlake Sleep Disorders Center keeps a record of the health care services provided and that I may request to review my record (a 24 hr notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Overlake Sleep Disorders Center to correct that record. Except as noted above, Overlake Sleep Disorders Center will not disclose my record unless I direct them to do so, unless the law authorizes or compels them. I may see my records or get more information about it from the medical records department at Overlake Sleep Disorders Center.

I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION AND THAT I UNDERSTAND IT'S CONTENT, MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM.

Signature of patient (if not a minor)_____Date_____Time_____

The patient is unable to consent because_____

Signature of parent/guardian/other_____Relationship_____Date_____Time_____

FINANCIAL AGREEMENT/PATIENT RESPONSIBILITIES:

You have the RESPONSIBILITY to:

- Provide accurate and complete details about your illness, hospitalization, medications and present conditions.
- Tell your doctor about any change in your condition or if problems arise.
- Tell your doctor or nurse if you do not understand your treatment or what you are expected to do.
- Accept financial responsibility for payment of services, pay your bill promptly or to inform OIMA Billing office if you are unable to pay your bill.
- Notify Overlake Sleep Disorders Center of any changes in healthcare benefits.

Initials _____ of Patient (if not a minor)

Initials _____ of Patient/Guardian or Other _____ Relationship_____ Witness_____

I UNDERSTAND THAT I CAN REQUEST A COPY OF OVERLAKE SLEEP DISORDERS CENTER'S NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES INFORMATION ABOUT HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED.

Initials_____ of Patient/Guardian * Initials imply full signature

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THE EPWORTH SLEEPINESS SCALE

Today's Date _____

How likely are you to doze off 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* 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	_____
Watching T.V.	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
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	_____

BED-PARTNER QUESTIONNAIRE

Name of Patient _____ Date _____

Name of person filling out this form _____

I have observed this person's sleep: ☐ Never ☐ Once or Twice ☐ Often ☐ Every Night

Check any of the following behaviors that you have observed this person doing while asleep.

☐ Light Snoring
☐ Loud Snoring
☐ Head rocking or banging
☐ Choking
☐ Pauses in breathing
☐ Occasional loud snorts
☐ Getting out of bed but not awake
☐ Twitching or kicking of arms during sleep
☐ Twitching or kicking of legs during sleep
☐ Crying Out
☐ Sitting up in bed not awake
☐ Biting tongue
☐ Sleepwalking
☐ Grinding teeth
☐ Other _____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

If so, please explain _____

Additional comments _____

_____

ABOUT FALLING ASLEEP

What time do you usually try to fall asleep?_____ ☐ a.m. ☐ p.m.

What time do you usually try to get up?_____ ☐ a.m. ☐ p.m.

Does this time vary/and if so, by how much? _____

How long does it usually take you to fall asleep?_____ hours _____ min.

On average, how many hours of sleep do you get each night?_____hours_____min.

When falling asleep or trying to fall asleep, how often do you?:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Have thoughts racing through your minds?	☐	☐	☐
Have anxiety(worry about things)?	☐	☐	☐
Feel afraid of not being able to sleep?	☐	☐	☐
Feel unable to move?	☐	☐	☐
Have creeping, crawling, aching, or twitching feelings in your legs (feel like you have to move them)?	☐	☐	☐
Have vivid, dream-like scenes even though you know you are not totally asleep?	☐	☐	☐
Have any kind of pain or discomfort?	☐	☐	☐

How many times do you usually awaken each night? _____

Do you have trouble getting back to sleep? ☐ Yes ☐ No

ABOUT SLEEPING

How often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Feel afraid you won't return to sleep after awakening?	☐	☐	☐
Sleep with someone else in your bed?	☐	☐	☐
Have restless, disturbed sleep?	☐	☐	☐
Snore loudly?	☐	☐	☐
Sweat a lot during the night?	☐	☐	☐
Walk in your sleep?	☐	☐	☐
Fall out of bed while sleeping?	☐	☐	☐
Wake up screaming, violent, or confused?	☐	☐	☐
Have unusual movements while asleep?	☐	☐	☐
Grind your teeth at night?	☐	☐	☐

Are you a: ☐ sound sleeper ☐ restless sleeper?

My sleep is frequently disturbed by: (CHECK ALL THAT ARE TRUE)

☐	Heat	☐	Creeping, crawling, or aching feelings in your legs (like you have to move them.)
☐	Cold	☐	Choking
☐	Noise	☐	Indigestion, "gas", or heartburn
☐	Need to urinate	☐	Noise or movement of your bed partner
☐	Cough	☐	Chest pain
☐	Shortness of breath	☐	Frightening dreams

ABOUT WAKING UP

How often do you:

CHECK ONE BOX FOR EACH STATEMENT	NEVER	SOMETIMES	OFTEN
Have a very hard time waking up?	☐	☐	☐
Feel unable to move when waking up?	☐	☐	☐
Have dream-like images when waking even though you know you are not asleep?	☐	☐	☐
Wake up confused or disoriented?	☐	☐	☐
Wake up with a headache?	☐	☐	☐
Wake up sick to your stomach?	☐	☐	☐
Wake up feeling rested?	☐	☐	☐
Wake up 1 or 2 hours before you have to get up?	☐	☐	☐

ABOUT DAYTIME FUNCTIONING

Do you take daytime naps? ☐ Yes ☐ No If yes, are they refreshing? ☐ Yes ☐ No

How long do you usually sleep during a typical nap? _____ hours _____ min.

How often do you:

Check one box for Each Statement	NEVER	SOMETIMES	OFTEN
Feel sleepy during the day?	☐	☐	☐
Fall asleep unintentionally? Please give an example: _____	☐	☐	☐
Feel sad or depressed?	☐	☐	☐
Have anxiety? (worry about things)	☐	☐	☐
Feel weakness in your muscles when laughing, surprised, angry, excited, etc.?	☐	☐	☐

OTHER QUESTIONS

Does anyone in your family have a sleep problem? ☐ Yes ☐ No

RELATIONSHIP TO YOU	DESCRIBE THE PROBLEM

How much of the following fluids do you drink?

	DURING A TYPICAL DAY	WITHIN 2 HOURS OF BEDTIME
Coffee - caffeinated	_____ cups	_____ cups
Coffee - decaffeinated	_____ cups	_____ cups
Tea	_____ cups	_____ cups
Soda	_____ cups	_____ cups
Beer	_____ cups	_____ cups
Wine	_____ cups	_____ cups
Other alcoholic beverages	_____ cups	_____ cups

Do you smoke cigarettes? ☐ Yes ☐ No

How much tobacco do you smoke during a 24 hour period? _____

MEDICATION HISTORY

Please list the name and dose (in mg.) of all medications you take now or within the past 30 days.

MEDICATION	DOSE	WHAT FOR?

Please list all the name of any pill for sleeping or to help you stay awake that you have taken in the past.

NAME	DID IT HELP?	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

HEALTH HISTORY

Please check any problem or illness you have or have had:

☐ Heart Disease	☐ Headache	☐ Black Outs	☐ Dizziness
☐ Back Trouble	☐ Asthma	☐ Cancer	☐ Seizures
☐ Depression	☐ Tuberculosis	☐ High Blood Pressure	☐ Epilepsy
☐ Fainting	☐ Hemophilia (Bleeding)	☐ Prostate Trouble	☐ Bronchitis
☐ Allergies	☐ Kidney Trouble	☐ Heartburn	☐ Diabetes
☐ Muscle Cramps	☐ Impotence	☐ Bladder Trouble	☐ Pneumonia

Please list any hospitalizations and/or surgeries you have had. Place the latest first.

_____

_____

_____

_____

_____

_____

Please list any allergies you have:

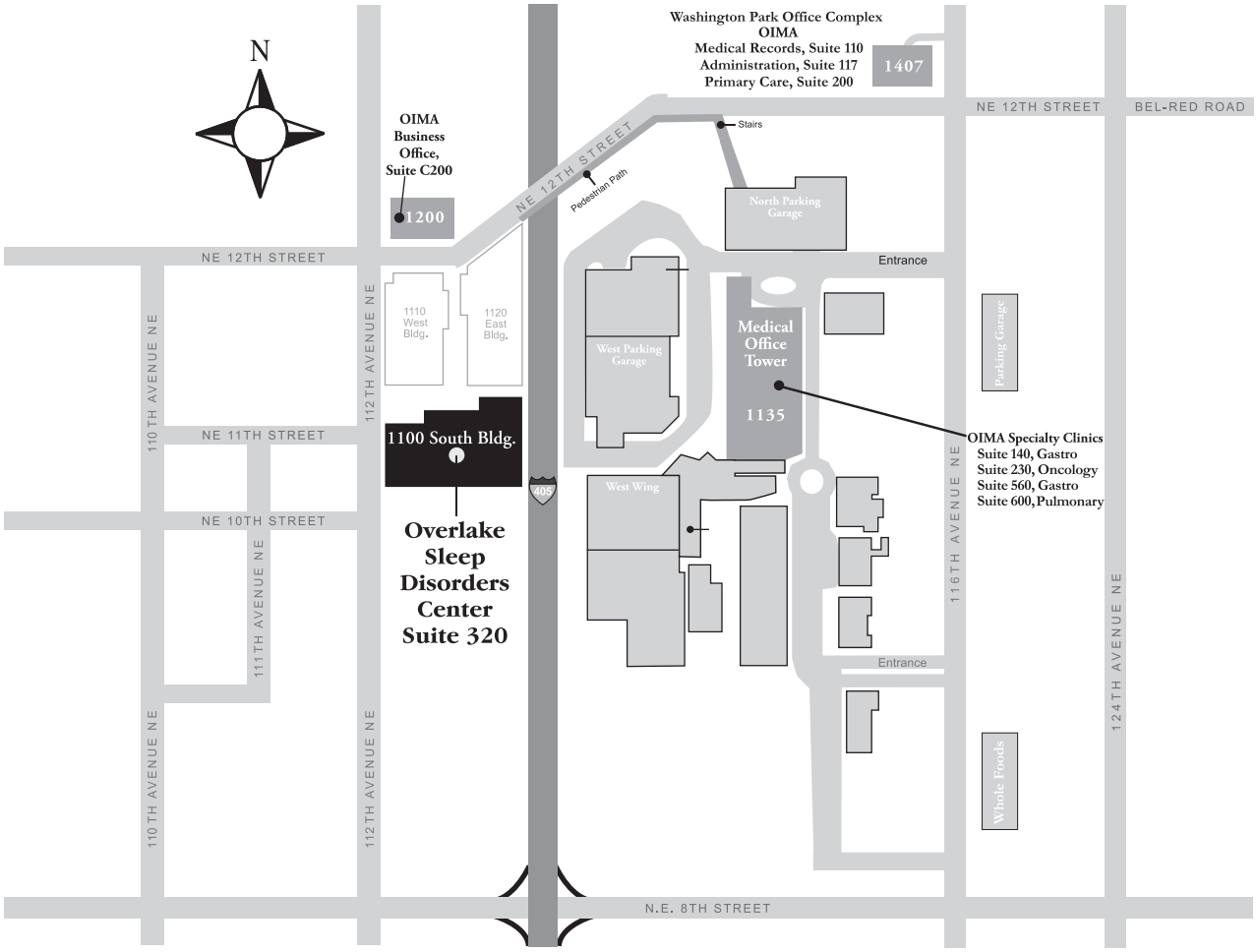
_____

_____

_____

Office Use Only: Height:_____ Weight: _____ B/P:_____

BMI:_____ Neck Size: _____



Overlake Sleep Disorders Center

1100 112th Avenue NE, Suite 320, Bellevue, WA 98004

425.289.3000

DIRECTIONS from I-405 Southbound

Take exit **#13B** - NE 8th Street **WEST** exit
Stay in far right lane on exit ramp
Make a sharp **right** onto 112th Avenue NE
Following 112th Avenue NE **go through** the NE 10th street light
Take next **right** into parking garage of **112th at 12th** corporate center

DIRECTIONS from I-405 Northbound

Take exit **#13B** - NE 8th Street **WEST** exit
Continue through ramp to the "**WEST"** NE 8th street exit
This ramp will put you onto NE 8th Street (heading west)
Turn **right** onto 112th Avenue NE (the next light)
Following 112th Avenue NE **go through** the NE 10th street light
Take next **right** into parking garage of **112th at 12th** corporate center

Proceed down the ramp into the parking garage and through the toll both. Turn right after the toll booth, following the "Red" South Elevator signage to the **1100 South Bldg.** parking area. Take the "Red" elevator to the 3rd floor – suite 320.

OSDC does not validate parking. For your convenience, the parking garage does accept credit and debit cards. If you prefer to be dropped off at our front door, please enter from 112th Avenue and proceed up the ramp to the patient drop off and pick up location.