Overlake Internal Medicine Associates, P.S.
Patient Profile

REFERRAL INFORMATION

Referred by Physician? O Yes O No

Referring Physician Name: ______________________ Referred by other (e.g., patient, website, ad) ______________________

PREFERRED PHARMACY

Pharmacy Name: ______________________

Location/Neighborhood: ______________________

Phone: ______________________

By signing below, I hereby authorize Overlake Internal Medicine Associates, P.S. to obtain my Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Printed name: ______________________

Signature: ______________________ Date: ______________________

OTHER DEMOGRAPHICS – ***(Federal Law Requires That We Ask the Following)***

Ethnicity: O Non-Hispanic or Non-Latino O Hispanic or Latino O Decline to answer

Preferred Language: O English O Other: __________ O Decline to answer

Race:
- O White
- O Asian
- O American Indian or Alaska Native
- O Black or African American
- O Native Hawaiian or Other Pacific Islander
- O Decline to Answer

EMERGENCY INFORMATION

Person to contact: ______________________ Phone #: ______________________

Relationship to patient: ______________________

May we take your photo to enhance your patient record? O Yes O No

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

Printed name: ______________________

Signature: ______________________ Date: ______________________

For official use only: Patient account number ______________________

Authorization for Overlake Internal Medicine Associates, P.S. (OIMA) to Use or Disclose Protected Health Information

Patient name: ____ Date of birth: ______________

I. The following is my authorization as it pertains to persons other than my healthcare providers (family, friends, business persons, etc.):

OIMA may use or disclose this health care information with/to: Name or title and relationship or organization:

____

____

Address(es) (optional): ____

Reason(s) for this authorization to use or disclose my health care information (☒ all that apply):

☐ my preference unless or until revoked ☐ other business purpose (specify)____________________

OIMA may use or disclose the following health care information (☒ all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating only to the following treatment(s) or condition(s):

____

☐ Health care information in my medical record for the date(s): ______________________

☐ Other (e.g. X-rays, bills, appt. dates/times), specify): ______________________

<u>**Uses and Disclosures Requiring Specific Authorization**</u>

OIMA may use/disclose health care information regarding tests, diagnosis, and treatment for (☒ all that apply):

☐ HIV/AIDS ☐ Drug and/or alcohol use ☐ Mental health or illness

☐ Sexually transmitted diseases ☐ Reproductive care (minors only)

Minors- *a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).*

This authorization ends:

☐ on (date): __________ ☐ when the following event occurs: ______________________

☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) from OIMA. However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by OIMA in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form which is available from OIMA, or write a letter to OIMA

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or entity that receives it may re-disclose it, which is beyond the control of OIMA and the protections intended by this form.

______________________________ ______________________________

Patient or legally authorized individual signature — Date — Time

______________________________ ______________________________

Printed name (if signed on behalf of the patient) — Relation (parent, legal guardian, personal rep)

______________________________ ______________________________

Minor patients signature, if applicable — Date — Time

Overlake
Internal
Medicine
Associates

Authorization to Leave Detailed Medical Messages

Including Voicemail, In-Person, or Other Authorized Forms of Communication

To an adult(s) age 18 or over only

Incomplete or illegible forms will not be processed

Purpose: Allow OIMA patients the opportunity to receive detailed information regarding their individual healthcare treatment, insurance, billing or other information relevant to their relationship with Overlake Internal Medicine.

______________________________	______________________	____________
Patient Last Name (Print)	**Patient First Name (Print)**	**Date of Birth**

MRN # (office use only):_________________ **Doctor:**______________________________

Authorization to Leave Detailed Medical Telephone Messages

Including Voicemail, In-Person, or Other Authorized Forms of Communication

This document authorizes OIMA the right to leave detailed medical messages related to specific medical information regarding, test results, patient instructions, follow-up care descriptions, medication refill status, referrals or billing and insurance information.

Restrictions (if applicable):____

I hereby authorize OIMA to leave detailed medical messages at the following telephone numbers

*Telephone #1: ______________________________ * Telephone #2:______________________________

* Indicates that telephone numbers above should belong to an adult 18 or older.

Conditions of Authorization:

1. **I understand that authorization may be granted only to individuals age 18 or over.**
2. **I understand that authorization does not include obtaining copies of electronic or written medical records.**
3. **I confirm that Overlake Internal Medicine has explained the limitation and restrictions that apply to this process.**
4. **I understand that detailed messages may not be left with me despite my authorization if determined to be in my best interest.**
5. **I understand that I am fully responsible for reporting changes to the phone numbers that I have provided.**
6. **I understand that authorization is effective on date of signature and expires after (3) three years.**
7. **I understand that this authorization may be revoked in writing at any time by contacting OSDC at (425) 289-3000.**

My signature below represents my voluntary request to make the above assignments and my full legal authority to do so.

______________________________	______________________________	____________
Patient's *Printed* Name	**Patient's Authorized *Signature***	**Date of Signature**

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:** ____________________

OVERLAKE SLEEP DISORDERS CENTER

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 of the Overlake Sleep Disorders Center.

AUDIO & VIDEO RECORDING: The use of audio and video monitoring and recording will be done in connection with my diagnosis, care and treatment at Overlake Sleep Disorders Center by the technical staff and physicians employed here.

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, its intermediary or another health care facility to provide continuity of care. 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 fee 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 ITS 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 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 inform OIMA's Business Office if you are unable to pay your bill.
- Notify Overlake Sleep Disorders Center of any changes in health care benefits.

Initials: ________of Patient (if not a minor)
Initials: ________of Patient and Guardian or Other (if patient is a minor), Relationship: ____________Witness:__________

I UNDERSTAND THAT I MAY 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: ______________ Of Parent, Guardian or Other: ______________ *Initials imply full signature

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:

SCALE: 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	______________
In a car, while stopped for a few minutes in traffic	______________

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 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

Overlake Sleep Disorders Center Referral Flow Sheet

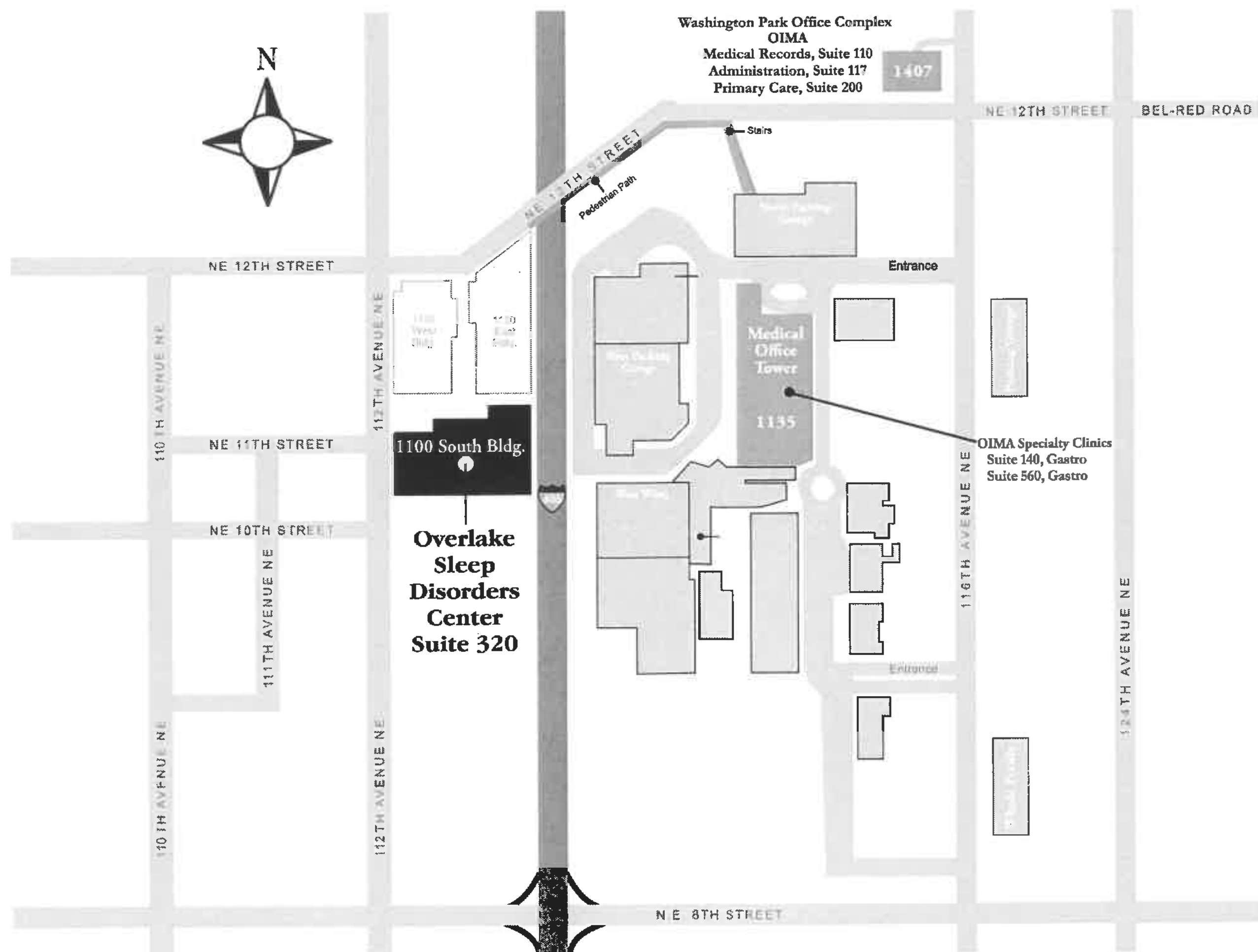
Welcome to the Overlake Sleep Disorders Center (OSDC). To assist you through your next steps with our office, we would like to share what to expect as you move through the initial referral, assessment and treatment process at OSDC. Please keep in mind that this is the most common flow of care at OSDC but each individual's care may vary slightly based on you unique needs and/or guidelines of your specific insurance plan.

- ☐ **Consultation with one of our sleep specialists:** You will be scheduled for a 40-minute consultation with one of our sleep physicians to begin the assessment process. Next steps regarding further assessment and/or treatment will result from this initial visit.
- ☐ **Appropriate sleep study (if indicated):** If your physician determines that additional information is needed to provide an accurate diagnosis, the appropriate sleep study will be recommended to you at the time of your consultation.
- ☐ **Prior authorization:** Based upon the requirements of your specific insurance plan, your sleep study may or may not require prior authorization. If prior authorization is required, this process may take up to two weeks, depending on your specific insurance company.
- ☐ **Receiving study results:** Your physician's nurse or medical assistant will contact you with the results of your study within 10 days of the date of your study and inform you of the next steps advised by your physician during that call. This step of the process will move most efficiently if results are reviewed by phone. However, if you prefer to see your doctor in person to review the results, we welcome you to schedule an appointment to do so.
- ☐ **PAP titration study (if indicated):** If PAP therapy is indicated as the best line of treatment, the next step will often be a second sleep study to determine the optimal pressure and setting for your PAP machine.
- ☐ **PAP set-up:** Once your PAP titration is complete, your physician will complete a prescription with the settings best suited to your individual needs. This prescription will be provided to the durable medical equipment (DME) company of your choice, who will then assure they have all supporting documentation in place to submit to your insurance company and process your order. As obtaining a benefits advisory, and potentially a prior authorization, will need to occur prior to scheduling you for set-up, it may take up to a week before you hear from your DME company to schedule you for this appointment.
- ☐ **DME follow-up assessment:** A respiratory therapist will follow-up with you (by phone, in person or both) to assure your new therapy is going well. If you are being serviced by OSDC's DME, we ask that you schedule a 2-week follow-up appointment in clinic with one of our respiratory therapists.
- ☐ **Physician follow-up:** To assure you receive the best care and to meet requirements set forth by your insurance plan to cover your PAP therapy, we advise you schedule a follow-up appointment with your physician 6-8 weeks after the initiation of your PAP therapy. We urge you schedule this appointment at the time of your set-up to assure a convenient and timely appointment with your physician is available to you.

We look forward to assisting you in attaining the good night's sleep you deserve! Please do not hesitate to contact our staff at (425) 289-3000 with any questions or concerns along the way.

ACCREDITED
MEMBER CENTER

Scott Bonvallet, M.D., FCCP • Randip Singh, M.D. • Reuben Walia, M.D.



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.