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): _____

Uses and Disclosures Requiring Specific Authorization

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

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AN INDEPENDENT MEDICAL GROUP
WWW.OIMA.ORG

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 #: _____

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

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

Neck Size: _____ Are you a shift worker? Yes____ No____ Shift Hours: _____

Allergies: _____

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:** _____

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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

Overlake Sleep Disorders Center

ACCREDITED
MEMBER CENTER

1100 – 112th Avenue NE, Suite 320
Bellevue, WA 98004
(425)289-3000 Fax (425) 289-3240

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

Name: _____ MR#: _____

Primary Care Physician: _____ Referring Physician: _____

1. What are your primary concerns about your sleep? _____
2. Have you ever had a sleep study? _____ If yes (please bring a copy of the report with you), when and where was the study done and what were the results? _____

   _____
3. Any recent CT scans of your head or sinus? MRI of brain? Chest X-ray or relevant scan? _____
4. Any recent Echocardiogram or EKG? _____
5. Any recent lab work (electrolytes, thyroid, CBC, B_{12}, Iron)? _____
6. Please list any hospitalizations and/or surgeries that you have had. List the most *current* first.

   _____
   _____
7. Have you ever seen an ear nose & throat specialist, pulmonologist, neurologist, psychiatrist or allergist?

   _____
   _____
8. Please list any **medication allergies** you have:

   _____
   _____

HEALTH HISTORY

Please check any problems or illnesses that you have had:

- ❑ Alcohol/Drug abuse
- ❑ Anemia or iron deficiency
- ❑ Anxiety
- ❑ Asthma
- ❑ Atrial fibrillation/Flutter
- ❑ Back Trouble
- ❑ Bladder Trouble
- ❑ Bronchitis
- ❑ Cancer (What type?)_____
- ❑ Cholesterol
- ❑ Depression/Bipolar
- ❑ Diabetes
- ❑ Dizziness
- ❑ Fibromyalgia or pain syndrome
- ❑ Headache
- ❑ Heart Disease
- ❑ Heartburn
- ❑ High Blood Pressure
- ❑ Impotence/Libido
- ❑ Kidney Trouble
- ❑ Loss of Consciousness
- ❑ Muscle Cramps
- ❑ Obesity
- ❑ Parkinson's Disease
- ❑ Pneumonia
- ❑ Prostate Trouble
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ TMJ
- ❑ Tonsillectomy
- ❑ Tuberculosis

9. Please list any medications you are currently taking including prescriptions and over the counter:

Medication	Dose/Frequency	Medication	Dose/Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

DIET & EXERCISE	✓ YES
How many beverages containing caffeine or Taurine (i.e. Red Bull) average per day?	
Do you exercise or have you had a recent change in exercise habits?	
Any changes in your diet recently?	
Any weight fluctuations? If so, increase or decrease?	
NASAL / SINUS	**✓ YES**
Tonsillectomy or Adenoidectomy?	
Chronic Sinusitis or postnasal drip?	
Nasal polyps or congestion?	
History of nasal fracture?	
Use of intranasal steroidal sprays?	
Seasonal allergies (trees, grass, mold, dust, animal dander)?	
Use of decongestants or antihistamines?	
Surgical interventions for sleep problems/nasal problems or sinus problems? (i.e., UPPP, resection of turbinates, septoplasty)?	
Do you sleep with your mouth open?	
DAYTIME FUNCTIONING	**✓ YES**
Is your motivation level low?	
Are you easily distracted?	
Do you lose focus when listening or have difficulty concentrating when you read?	
Do you need instructions repeated or have difficulty tracking two things at once?	
Do you have difficulty finding words while talking or difficulty with mental arithmetic?	
Are you depressed?	
Are you irritable or would your significant other say that you are irritable?	
Are you impulsive or impatient?	
Do you have difficulty with your short-term memory?	

ENVIRONMENT

Please check any of the following that are in your sleeping environment:

- ❑ Appliances (i.e., Washer/Dryer or Dishwasher)
- ❑ Bed partner
- ❑ Children
- ❑ Computer
- ❑ Light
- ❑ Noise
- ❑ Pets
- ❑ Television
- ❑ Other _____
- _____
- _____

SLEEP HABITS	✓ YES
Have you ever taken any prescription or over the counter medication to help you sleep? If so, what have you taken?	
Is 8 hours of sleep necessary?	
Do you take naps?	
Do you read, watch television or use the computer before bed?	
Do you eat or snack prior to going to bed?	
Do you have racing thoughts while you are in bed?	
Have any of your medications changed the quality of your sleep?	
Do you currently or have you ever worked nights?	
SLEEP SCHEDULE	
How long does it take you to fall asleep?	
What is your bedtime?	
How often do you wake up in the middle of the night?	
If you wake up from sleep, how long does it take you to fall back asleep usually?	
What time do you wake up in the morning?	
Do you take naps? If so, for how long?	
Do you sleep in on the weekend?	

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Name of person completing this section: _____

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 sleeping**:

- ❑ 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 _____

SLEEP RELATED PHENOMENA	✓ YES
Headache? If yes, have you experienced any: ☐ numbness ☐ tingling ☐ changes in vision ☐ rapid heartbeat ☐ tearing or light sensitivity	
Witnessed apnea or pauses in breathing?	
Night sweats?	
Snoring? If yes, any changes in intensity or duration?	
Nodding off behind the wheel of a motor vehicle?	
Have you experienced choking, gasping arousals or snorting?	
Do you grind your teeth? If yes, do you wear a mouth guard?	
Do you have heartburn during the day or at night?	
While awake, have you had any shortness of breath when lying on your back?	
Have you ever been on a ventilator?	
Any swelling in your legs?	
Is your sleep worse before your menstrual cycle?	
Cyanosis in the morning (skin is blue)?	
Have you ever had the carbon monoxide levels checked in your home?	
Sleep walking, talking, eating; night terrors or waking up screaming?	
Do you act out your dreams (e.g. punching or kicking)?	
Coarse breathing or wheezing at night?	
Do you frequently wake up to urinate at night?	
Do your legs cramp at night?	
Do you feel discomfort in your legs? If yes: ☐ Is it more noticeable at night? ☐ Does it improve with movement?	
Have you ever felt weak during a bout of laughter?	
Have you ever woken up in the middle of a dream unable to move?	
Do you dream during naps?	

How likely are you to doze off or fall asleep in the following situations?
SCALE: 0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance

SITUATIONS	SCALE
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place	0 1 2 3
As a passenger in a car	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

What is your **Family Medical History**?:

Father:_____

Mother:_____

Social History:

Occupation:_____

How many alcoholic beverages do you average in a week?_____

Do you use tobacco, if so, how often?_____

Do you use any illicit drugs and if so which one(s)?

_____

_____

_____

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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 ***10-14 working 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.

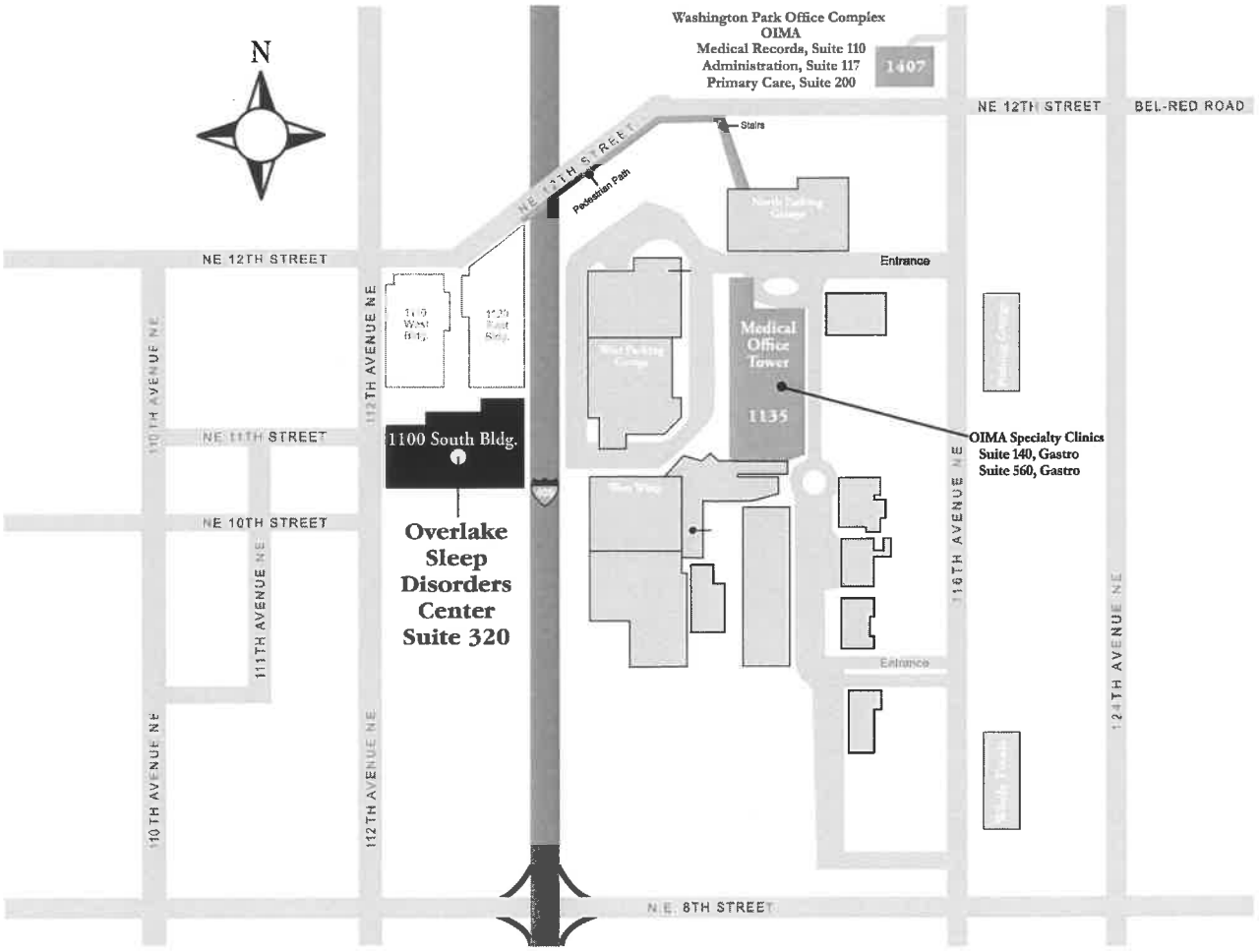
Physician follow-up: To assure you receive the best care and to meet requirements set forth by your insurance plan to cover your PAP therapy, we advise you schedule a follow-up appointment with your physician 6-8 weeks after the initiation of your PAP therapy. We urge you schedule this appointment at 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.

Scott Bonvallet, MD, FCCP

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP
ACCREDITED MEMBER CENTER

Randip Singh, MD



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.