



NEW PATIENT FORM:

PATIENT INFORMATION: FIRST NAME: _____ LAST NAME: _____ MI: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best time to call : Morn/Noon/Night Call: Home/Cell/Work Email: _____

DOB: ___/___/___ SS# _____ Height : _____ Weight: _____

Address: _____ City _____ State _____ Zip _____ Marital Status: S/M/D/W

Emergency Contact: _____ Relationship: _____

Phone: _____ Referred by: _____

EMPLOYER INFORMATION: Employer: _____ Phone: _____ Fax: _____

Address: _____ City _____ State _____ Zip _____

INSURANCE INFORMATION: Insurance Company Name: _____

Group Policy #: _____ Group Name: _____ Insurance ID#: _____ Plan Name: _____

Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company

FIRST NAME: _____ LAST NAME: _____ MI: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ DOB: ___/___/___

Email: _____ Employed by: _____

Address: _____ City _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION: Insurance Company Name: _____

Group Policy/TWCC #: _____ Group Name: _____ Insurance ID#: _____ Plan Name: _____

Relationship to Insured: Self/Spouse/Parent/Legal Guardian/Company

FIRST NAME: _____ LAST NAME: _____ MI: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ DOB: ___/___/___

Email: _____ Employed by: _____

Address: _____ City _____ State _____ Zip _____

MEDICAL CONTACTS: *Good Night El Paso* coordinates treatment with your other medical providers to ensure

maximum benefit to you. Where applicable, please list your other medical providers:

PRIMARY CARE DOCTOR: _____ PHONE: _____
ENT: _____ PHONE: _____
SLEEP DOCTOR: _____ PHONE: _____
DENTIST: _____ PHONE: _____
OTHER DOCTOR: _____ PHONE: _____
OTHER DOCTOR: _____ PHONE: _____

Chief Complaints

- Clenching teeth
- Excessive daytime drowsiness
- Fatigue
- Impaired thinking
- Intolerance to CPAP
- Memory problems
- Morning headaches
- Nightmares
- Snoring
- TMJ or Jaw pain
- Trouble concentrating
- Waking unrefreshed
- Witnessed choking or gasping during night

Allergens Select any medications or other items that have caused an allergic reaction

- Antibiotics
- Metal Allergy
- Aspirin
- Barbiturates
- Codeine
- Iodine
- Latex
- Local anesthetics
- Metals
- No known allergens
- Penicillin
- Plastic
- Sedatives
- Sleeping pills
- Sulfa drug

Current Medications

Please add all medications you are currently taking.

New Medication:

Medical History

- | | | |
|---|---|--|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Nasal allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neuralgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Blood pressure - High | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Prior orthodontic treatment |
| <input type="checkbox"/> Blood pressure - Low | <input type="checkbox"/> Heart pacemaker | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Bruising easily | <input type="checkbox"/> Heart valve replacement | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Immune system disorder | <input type="checkbox"/> Tendency for ear infections |
| <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> Ischemic heart disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Urinary disorders |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Meniere's disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> None |
| | <input type="checkbox"/> Mood disorder | |

Surgical Operations

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Back | <input type="checkbox"/> Lung | <input type="checkbox"/> Uvulectomy |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Nasal | |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Periodontal | <input type="checkbox"/> Other |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Thyroid | _____ |

Family History

Has any member of your family had

- | | |
|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mother has sleep apnea |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mother Snores |
| <input type="checkbox"/> Father has sleep apnea | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Father Snores | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disorder |

Social History

Current Employment Status: _____

Tobacco Use:

Cigarette and/or Tobacco use

- Current
- Quit
- Caffeine
- No
- Yes

Alcohol

Do you drink alcohol? Yes No Do you drink Caffeine: Yes No

Have you previously had a sleep Study? Date: _____

Snoring History

Frequency: Never Daily Often

Severity: Light Moderate Loud

Sleep

How long does it take you to fall asleep? _____ Normal Bedtime? Yes No

Avg Hrs sleep per night? _____

Epworth sleep questionnaire

No Chance Of Dozing **0** **Slight Chance Of Dozing** **1**

Moderate Chance Of Dozing **2** **High Chance Of Dozing** **3**

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place(e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while stopped for few minutes in traffic	0	1	2	3

Other Sleep Therapy Attempts

- | | |
|--|--|
| <input type="checkbox"/> BiPAP | <input type="checkbox"/> Smoking cessation |
| <input type="checkbox"/> CPAP | <input type="checkbox"/> Surgery(Uvulectomy) |
| <input type="checkbox"/> Dieting | <input type="checkbox"/> Surgery(Uvuloplasty) |
| <input type="checkbox"/> Nasal strips | <input type="checkbox"/> Uvulectomy(But continues to have symptoms) |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Uvuloplasty(But continues to have symptoms) |
| <input type="checkbox"/> Pillar procedure | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Positional therapy(Side sleeping) | |

Sleep History

Previously diagnosed with Obstructive Sleep Apnea? Date: _____

Sleep Treatment History

What treatments have you had for this issue and where did you have it performed?

Date: _____ Treatment _____ Where _____

Physician's Name: _____ Phone : _____

I CERTIFY THIS INFORMATION IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature: _____

DATE: ___/___/___

RIGHTS AND RESPONSIBILITIES

You have the right to:

- Be treated in a dignified and respectful manner and to receive reasonable responses to reasonable requests for service.
- Respect your cultural and personal values, beliefs and preferences.
- Personal privacy, privacy of your health information and to receive a notice of the facility's privacy practices.
- To access, request amendment to and obtain information on disclosures of your health information in accordance with law and regulation within a reasonable time frame.
- Care or services provided without discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, Sexual orientation, and gender identity or expression.
- Participate in decisions about your Care, including developing your treatment plan
- Refuse care, treatment or services in accordance with law and regulation.
- Receive information about the outcomes of your care, treatment and services, including unanticipated outcomes.
- Give or withhold informed consent when making decisions about your care, treatment and services.
- Receive information about benefits, risks, side effects to proposed care, treatment and services; the likelihood of achieving your goals and any potential problems that might occur during treatment and services and any reasonable alternatives to the care, treatment and services proposed.
- Give or withhold informed consent to recordings, filming or obtaining images of you for any purpose other than your care.
- Be free from neglect exploitation; and verbal, mental, physical and sexual abuse.
- An environment that is safe, preserves dignity and contributes to a positive self-image.
- Examine and receive an explanation of the bill for services, regardless of the source of payment.

Your Responsibilities:

- Provide accurate and complete information concerning your present medical conditions, past illnesses or hospitalization and any other matters concerning your health.
- Notify us if your insurance, address, phone number, etc., changes.
- Tell your provider(s) if you do not completely understand your plan of care.
- Follow the Provider(s) instructions.

INITIALS

MEDICAL BILLING AUTHORIZATION

Your signature is necessary for us to:

- Process all insurance claims
- Ensure payment for services provided
- Release medical information to insurance companies needed for the processing for your claims
- Release information to other medical and dental providers, including laboratories, when necessary, for your treatment.

I hereby authorize the release of all medical information necessary to process my claims. I authorize release of this same information, when necessary, to other providers rendering medical/dental care, as well as to labs that need my information to make diagnosis or fabricate an appliance necessary for my treatment.

I assign all medical benefits, including major medical benefits to which I am entitled, to Dr. _____ of _____ (practice name). This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Patient / Guardian Signature: _____

Printed Name: _____ Date: _____



Office Hours:
Monday- Closed Tuesday-Thursday 9:00am-6pm Friday-9:00am-2pm

AFTER HOURS POLICY

After Hours Access – Telephone

Patients can call the office phone number (915)219-9733 and leave a message at our secure voicemail. Patients are informed that their call will be returned the next business day.

COMPLAINTS AND GREVIANCES

Good Night El Paso, LLC will document issues and will include:

- Date complaint was received, by whom
- Name, address, and contact number of individuals contacting **Good Night El Paso, LLC**
- Issue or complaint
- Investigation and response to the complaint
- Resolution of issue with attached documentation, when necessary
- Any payer requirements (i.e. Medicare HIC number)

Within five (5) calendar days of receiving a beneficiary's complaint, the supplier shall notify the beneficiary, using either oral, telephone, email, fax, or letter format, that it has received the complaint that it is investigating.

Within fourteen (14) days, the supplier shall provide written notification to the beneficiary of the results of its investigation and response.

Good Night El Paso, LLC maintains documentation of all complaints that it receives, copies of investigations, and responses to beneficiaries.

Signature

Date



Assignment of Benefits

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization. I hereby assign and convey directly to the below-named health care provider ("Provider"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of its managed care network participation status.

I understand that I am financially responsible to the Provider for any charges regardless of health care benefits. It is my responsibility to notify the Provider of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I hereby authorize the Provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the Provider or its attorneys in order to claim such medical benefits.

In addition, I also assign and/or convey to the Provider any legal or administrative claim or choose an action arising under any group health plan, employee benefits plan, health insurance or tort fees or insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the Provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the Provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (Provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

PROVIDER: Dr. Adela Cabrera

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____	_____	_____
Patient/Parent Signature	Printed	Date
_____	_____	_____
Witness Signature	Printed	Date

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have received the following notices & documentation:

- Medicare Supplier Statement (If Medicare Patient only)
- Rights and Responsibilities
- HIPAA Privacy Policy
- After-Hours Policy
- Complaint Policy
- Financial Documentation

Patient Name: _____

Date of Birth: _____

Patient Signature Date

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Medicare Patients

The product and/or services provided to you by SOA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://www.ecfr.gov>. Upon request we will furnish you with a written copy of the standards.

Patient Signature Date



PATIENT COMMUNICATION CONSENT FORM

I authorize Good Night El Paso, LLC to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize Good Night El Paso, LLC to leave DETAILED messages for me when I am unavailable.

Table with 4 columns: METHOD, NUMBER, DETAILED MESSAGES, (YES OR NO). Rows include Home Phone, Cell Phone, Text Messages, and Email.

I authorize Good Night El Paso, LLC and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Table with 3 columns: NAME, RELATIONSHIP, CONTACT INFO. Includes three blank rows for contact information.

EMERGENCY CONTACT ONLY - NAME: Phone:

In general, the HIPPA privacy rule gives individuals the right to request on uses and disclosures of their protected health information (PHI) the individual is also provided the right to request confidential communication.

By my signature below I acknowledge that I have read and understand the Guidelines to Patient Communication and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guideline as well as any other instruction that Good Night El Paso, LLC may impose.

Patient/Guardian Signature Printed Date

I also understand that I have the right not to sign this agreement.

- Patient decline to sign agreement

Signature Witness Date