

# ***FOUNTAIN VALLEY REGIONAL SLEEP CENTER***

**"The Path to Healthy Sleep"**

## ***Welcome!***

The physicians and staff at the ***Fountain Valley Regional Sleep Center*** appreciate your choice of our center to evaluate the cause of your sleep disturbance. We hope that your experience with our sleep center will be as comfortable as possible.

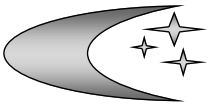
In an effort to streamline the admissions process please take a moment to fill out the paperwork provided here in the admissions packet. Then bring the completed paperwork with you on the night of your evaluation. Please inform the lab technicians prior to your arrival if you have any special needs (e.g., handicapped, extra blankets, fan, etc.) at (714) 427-5900. Please be advised, there is **\$150.00 cancellation fee for any appointment canceled with less than 48hrs notice**, so please make every attempt to make it to your scheduled appointment.

It is our intension to provide the highest level of service possible, so please remember to fill out the **Patient Satisfaction Survey** after you have completed your sleep evaluation. This will help us better serve our patients and customers in the future. Again, thank you for your time and consideration; we look forward to seeing you at the center in the near future!

Sincerely,

Andrew Arambula  
President & CEO





**FOUNTAIN VALLEY REGIONAL SLEEP CENTER**  
"The Path to Healthy Sleep"

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Male  Female Marital Status:  Married  Single  Widow Age: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_

Employer: \_\_\_\_\_ Work/Contact #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Last Name First Name

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

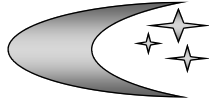
<b>Spouse Information</b>
Spouse's Name: _____ Last First
Employer: _____ Work/Contact #: (____) _____
Date of Birth: ____/____/____ Social Security #: _____-____-____

<b>Insurance Information</b>
Primary Insurance: _____ Name of Insured: _____
Insured ID #: _____ Group #: _____ Plan #: _____
Secondary Insurance: _____ Name Of Insured: _____
Insured ID #: _____ Group #: _____ Plan #: _____
Referred By: _____ Phone #: (____) _____
Medications Allergic to: _____

**Signature on File:** I requested that payment of authorized medical benefits be made directly to Fountain Valley Regional Sleep Center, Inc. and authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agencies any medical information necessary to determine these benefits payable for related services. I understand that my signature requests that payment be made and authorized the release of any information needed to process the claim(s) with insurance company and/or to release medical records on my behalf to attorneys or other physicians who may consult on my case. I also understand that I am responsible for any co-payments, deductibles, and non-covered services at the time of the office visit. Rebilling fees will incur on past due accounts.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_





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## **Patient Record of Disclosure**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check All That Apply)

Home Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave message with call- back number only

Work Telephone \_\_\_\_\_

O.K. to leave message with detailed information

Leave message with call back number only

Cell Phone \_\_\_\_\_

O.K. to leave message with detailed information

Leave message with call back number only

Written Communication:  O.K. to mail to my home address

O.K. to mail to my work/ office address

Other

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Canceled/ Missed Appointments: Patient Initials \_\_\_\_\_

A scheduled appointment means that time is reserved for you. If an appointment is missed or canceled with less than 48 working hours' (one full working day's) notice, a \$150.00 fee will be billed to you.

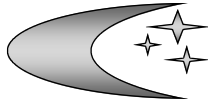
We accept **Visa** or **Mastercard**.

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Day of Birth \_\_\_\_\_

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**Authorization to Assign Benefits to Provider**

I hereby request payment of my authorized Medicare or other carrier benefits to be made on my behalf to Fountain Valley Regional Sleep Center for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to release to the Health Care Financing Administration, any other insurer and/or their agents any information needed to determine these benefits. Fountain Valley Regional Sleep Center bills third party payers as a courtesy when appropriate. I understand that I am fully responsible for all deductibles, coinsurance and disallowed items. Also, I understand that a particular item or services, although it would otherwise be covered, if not "reasonable and necessary" under Medicare standards, Medicare will deny payment. We believe that, in your case, Medicare or another carrier is likely to deny payment for the following reasons:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If signed by caregiver or other, please list relationship (I.E. Husband, Wife, R.N., etc.)*



*Accepted*



# ***FOUNTAIN VALLEY REGIONAL SLEEP CENTER***

## **SLEEP STUDY INFORMED CONSENT FORM**

A sleep study or polysomnogram (PSG) is an overnight test during which several physiologic functions are monitored. These include brain activity, eye movements, muscle tone, heart rhythm, airflow from the nose and mouth, breathing effort, blood oxygen levels and leg movements. Attaching small gold electrodes to the surface of the scalp or skin monitors most of these functions. The skin is not punctured.

Six (6) electrodes attached to the scalp monitor brain activity. The electrodes are attached with paste which is easily removed in the morning. The patient's brain activity is monitored to determine if, during the course of the sleep study, the patient is asleep or awake and to determine the patient's then current sleep stage(s).

The patient's eye movements are measured by placing snap electrodes near the outer edge of each eye. Eye movements are measured to determine if the patient is in the stage of sleep where vivid dreaming occurs (rapid eye movement sleep). Removing the electrodes in the morning may be mildly uncomfortable. Muscle tone is measured by placing two (2) electrodes—both are placed on the patient's chin. Muscle tone is also measured to help determine if the patient is in rapid eye movement sleep. Heart rhythm is measured by placing two (2) electrodes on the chest.

Airflow from the nose and mouth are measured by taping a small device called a thermistor beneath the nose. Airflow is measured to determine if the patient is experiencing sleep apnea/hypopnea syndrome. This is a disorder in which there are either pauses in airflow (apnea) or reductions in airflow (hypopnea) during sleep due to obstruction of the upper airway. Breathing effort is measured by placing elastic belts around the chest and abdomen. These electrodes are placed over the pajamas and help to determine the type of breathing problems that are occurring.

Blood oxygen level is measured by placing a small device on the finger. This device shines a small red light into the finger and is completely painless. Leg movements are measured by placing two (2) electrodes on each leg. Leg movements are measured to determine if the patient has a disorder in which the legs twitch repeatedly throughout the night (periodic limb movement disorder).

Each patient bedroom has a television and a comfortable bed. Electrode attachment takes about an hour. Usually three (3) patients undergo sleep studies each night (each patient has a private room). A patient will go to bed with lights out between 10:00 p.m. and 11:00 p.m. Lights on time is usually around 6:00 a.m. After the electrodes are attached, the electrode wires are wrapped into a bundle to prevent tangling. All the wires plug into a small box that is connected to recording equipment in a nearby control room. If the patient needs to visit the restroom during the night, the box can be unplugged and carried into the restroom. It takes about five (5) minutes to disconnect all the electrodes in the morning.

Continuous positive airway pressure (or CPAP) may also be used during the patient's sleep study. A CPAP machine is a device that delivers room air through a hose and into a mask that is worn over the nose. The nasal mask is kept in place by elastic headgear. The incoming air helps to prevent the upper airway from collapsing, thereby eliminating the breathing pauses that are occurring in sleep apnea syndrome.

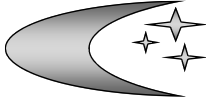
There are no known side effects (or material risks) associated with the performance of a sleep study. Fountain Valley Regional Sleep Center is required to disclose or report certain medical diagnosis information to local health departments or the Center for Disease Control and prevention. Reportable information includes cases of HIV, tuberculosis, viral meningitis and certain other diseases. I understand that, once the sleep study is commenced, a patient may terminate the sleep study at any time.

I AGREE TO UNDERGO THE SLEEP STUDY AS ORDERED BY MY PHYSICIAN

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date



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**Patient's Rights**

All patients shall have right's which include, but are not limited to the following:

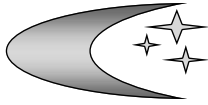
- To be given a statement of services available by the agency and related charges.
- To have access to the services, regardless of race, religion, sex or source of payment.
- To have the right to request and receive an itemized and detailed explanation of the total bill for services rendered and products supplied.
- To have access to the physician directing his/her care, information regarding his/her diagnosis, and treatment and prognosis.
- To be allowed to participate in the "plan of care", including discharge planning and to participate in decisions regarding his/her diagnosis, treatment or prognosis.
- To be communicated to in a way that he/she can reasonably, expect to understand
- To be informed about nature of any technical procedure that will be performed, as well as who will perform the procedure.
- To have rights to refuse treatment (as permitted by law) and be informed of the medical consequence's of such refusal.
- To request to view policies and procedures of Fountain Valley Regional Sleep Center, Inc.
- To seek assistance in finding and transferring the provision of services to another agency.
- To receive care in a timely manner, appropriate to his/her needs.
- To be treated with consideration, respect and full recognition of his/her dignity, individuality, and privacy. To be assured of confidentiality in treatment and records of such, and allowed to approve or refuse their release to any outside agencies.
- To have competent and qualified personnel carry out the services for which they are responsible.
- To be provided access to the state Health Department for problems about services.
- To voice grievances and recommend changes in policies and services. The patient will be informed of Fountain Valley Regional Sleep Center, Inc. mechanism for receiving, and resolving patient complaints.
- To be allowed to have patient's family or guardian exercise the patient's rights when patient has been judged incompetent.

**Patient's Responsibilities**

All patients shall have responsibilities, which include, but are not limited to the following:

- To provide, to the best of his/her knowledge, accurate and complete information about present medications and/or other matters relating to his/her healthcare.
- To report unexpected changes in his/her condition to those clinicians responsible for the management of his/her care.
- To make it known whether he/she clearly understands a contemplated course of action and what is expected of him/her.
- To inform Fountain Valley Regional Sleep Center, Inc. of any advance directive he/she may have.
- To follow the treatment plan recommended for his/her care by the primary care physician and other allied health professionals, including nurses, pharmacists, and dieticians.
- To keep appointments and, when unable to do so for any reason to notify Fountain Valley Regional Sleep Center, Inc. no later than 48 hours prior the scheduled appointment and make a new appointment.
- To assume responsibility for his/her actions if he/she refuses treatment or does not follow the instructions as set forth by his/her primary care physician and the professional staff of Fountain Valley Regional Sleep Center, Inc..
- To assure that the financial obligations of his/her health care are fulfilled as promptly as possible.
- To be considerate of the rights of Fountain Valley Regional Sleep Center, Inc. personnel or representatives.
- To be respectful of the property of Fountain Valley Regional Sleep Center, Inc and of its personnel.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Sleep Assessment and Epworth Scale**  
(Questionnaire used to identify sleep disorder candidates)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Please list any medical problems with-in the last 5 years (hypertension, diabetes, surgeries, etc...)

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Have you suffered from Heart Attack or Stroke? \_\_\_\_\_ When? \_\_\_\_\_

- |  |     |    |              |
|--|-----|----|--------------|
| 1. Do you snore at night   | yes | no | occasionally |
| 2. Witnessed pauses in breathing while asleep  | yes | no | occasionally |
| 3. Do you have difficulty falling asleep   | yes | no | occasionally |
| 4. Do you have difficulty maintaining sleep  | yes | no | occasionally |
| 5. Experience a restless sensation in legs while lying awake   | yes | no | occasionally |
| 6. Kicking and twitching movements while asleep  | yes | no | occasionally |
| 7. Experience excessive daytime tiredness  | yes | no | occasionally |
| 8. Have you ever awakened feeling paralyzed  | yes | no | occasionally |
| 9. Experience a sudden loss of strength in your arms or legs   | yes | no | occasionally |
| 10. If previous answers yes, were these events brought on by<br>a sudden frightening event or laughter | yes | no | occasionally |

Do you frequently awaken with? (please circle all that apply)

Dry mouth      Nasal Congestion/Headache      Heartburn      Chest Pain  
Sweating      Choking or Gaspings      Feeling Groggy or Unrefreshed

According to the following scale choose the appropriate number value to represent how likely you are to fall asleep during the day in the following situations. Try to be as honest as possible. If possible have your significant other help you fill this out.

<b>0-never</b>	<b>1-slight chance</b>	<b>2-moderate</b>	<b>3-always</b>
Sitting and Reading	0	1	2 3
Watching T.V.	0	1	2 3
Sitting, inactive in a public place (movie, theater, meeting)	0	1	2 3
Sitting and talking to someone	0	1	2 3
Sitting quietly after lunch without alcohol	0	1	2 3
As a passenger in a car for an hour without a break	0	1	2 3
Driving a vehicle for two or more hours	0	1	2 3
<u>Lying down to rest in the afternoon when circumstances permit</u>	0	1	2 3

Total \_\_\_\_\_



# Patient Satisfaction Survey

Date of Study: \_\_\_\_\_

Technician: \_\_\_\_\_

Please take a couple minutes to complete this questionnaire. The questions below help us improve the level of service we are able to provide for our patients.

## Office Staff

Poor(1) to Excellent(5)

- |  |     |   |    |   |   |
|--|-----|---|----|---|---|
| 1. Was your call handled in a courteous, helpful manner?     | 1   | 2 | 3  | 4 | 5 |
| 2. Did you receive a call to remind you of your appointment? | Yes |   | No |   |   |
| 3. Did you receive your questionnaires in the mail or email? | Yes |   | No |   |   |

## Technical Staff

- |   |     |   |    |   |   |
|---|-----|---|----|---|---|
| 1. How well did the Technician explain the testing procedure? | 1   | 2 | 3  | 4 | 5 |
| 2. How courteous was the Technician?                          | 1   | 2 | 3  | 4 | 5 |
| 3. How professional was the Technician?                       | 1   | 2 | 3  | 4 | 5 |
| 4. Did the Technician explain and demonstrate Nasal CPAP?     | Yes |   | No |   |   |
| 5. Was the Technician on time?                                | Yes |   | No |   |   |

## Testing Area (Laboratory Studies)

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. How was the comfort and cleanliness? | 1 | 2 | 3 | 4 | 5 |
| 2. How comfortable was the bed?         | 1 | 2 | 3 | 4 | 5 |
| 3. How quiet was the facility?          | 1 | 2 | 3 | 4 | 5 |

Thank you for choosing **FOUNTAIN VALLEY REGIONAL SLEEP CENTER**. We are dedicated to providing the highest level of service possible. Your comments and feedback help us maintain highest level of care possible. List any additional comments below **(Patient name is optional)**.

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**Thank you for choosing us!**

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[www.beachsleeper.com](http://www.beachsleeper.com)