COASTAL DIAGNOSTIC TESTING GROUP, LLC
475 ELMIRA AVE SE SUITE 101
BANDON, OREGON 97411
PHONE: (541) 329-0099 FAX: (541) 329-0063

ACKNOWLEDGEMENT AND CONSENT

I understand that Coastal Diagnostic Testing Group, LLC (referred to below as "The Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate amount, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan and insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and review written description of how this Practice will handle health information about me. This written description is known as a Notice of Privacy Policy and describes the uses and disclosures of health information made and the information practices followed by the employee, staff and other personnel of This Practice, and my rights regarding my health information.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Policy, and I understand that This Practice is not required by law to agree to such requests.

I understand that if I fail to sign this Acknowledgement and Consent that This Practice will not bill my insurance on my behalf and I will be responsible for paying for services in full at the time they are performed.

By: ______________________________ Date: ____________________
Responsible Party Signature

____
Printed Name

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Financial Policy

The following is the terms and conditions of our Financial Policy, which has been developed in an effort to remove any misunderstanding that may arise in regards to your account. Our main concern is for you to receive the highest level of quality care and personal service. If you have any questions about our Financial Policy please call us.

We ask that all patients read and sign the Financial Policy and complete the Patient Information Packet.

Fees and Payment Policies

1. Co-Pays, deductibles, and co-Insurances are due at the time of service. We will provide you with an estimate of charges at the time of service for ease of payment. It is understood that your final charges will depend on actual services received, which may or may not exceed our estimates.
2. Self-Pay patients are given a discount and are expected to pay at the time of service. *(A Self-Pay patient constitutes a patient with **no insurance**, not a patient with insurance and high deductibles.)*
3. Past due accounts, those older than 90 days, or failure to honor agreed-upon payment terms, will be sent to a collection agency. If it is necessary to refer this account for collections, patient agrees to pay agent reasonable attorney fees and collection costs, including any collection fees charged by a collection agency, even though no suit or action if filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including any appeal therein, is tried, heard or decided. I understand that the above clause is referencing to the services provided by Coastal Diagnostic Testing Group LLC. ______________________ ______________
   Sign Date
4. Sleep Lab appointments must be cancelled **24 hours before** your appointment. A fee of **$300** will be assessed if you do not cancel within that time frame. The fee is not covered by your insurance, and it is **your responsibility to notify the office should you need to cancel.**
5. We accept Medicare. If you have supplemental insurance we will bill your supplement as a courtesy, after Medicare has processed their portion. You must provide us your supplemental insurance information in order for us to do so.
6. We will bill most primary insurance companies. Secondary insurances are billed as a courtesy to patients.
7. Copies of your insurance cards will be made every visit. **It is the responsibility of the patient** to notify us if insurances changes.
   a. If your insurance company has not paid within 45 days, the balance will become the patient's balance.
   b. Every insurance policy is different, and it is the patient's responsibility, not the provider, to know what is covered and excluded from the insurance plan, as well as co-pays, co-insurance, and deductible information.
8. All returned checks are subject to a $40.00 fee.

We thank you for choosing us and appreciate the opportunity to serve you.

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Financial Policy.

X______________________________ Date__________________
Signature of Patient or Responsible Party

X______________________________ Date__________________
Signature of Co-Responsible Party

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PATIENT INFORMATION

Name: ______________________________________ Sex:(M/F)________
Last First Middle

Date of Birth:______/______/______ Height: ______Feet_____Inches Weight:_________Lbs.

Soc. Sec. #_______-________-_______ Marital Status:________ Email: ______________

Address: ______________________________City: ____________State: ____ Zip Code: ________

Home Phone: _______________Cell: _______________ Drivers License #: _______________

EMERGENCY CONTACT:
Name: ______________________________ Relationship to Patient: ______________________

Address: ______________________________________ Phone #: ______________________

PRIMARY INSURANCE

Primary Insurance: ______________________________________Phone #:________________

Billing Address: ____

Group #:_____________ Insurance ID#:_____________ Insured Person Date of Birth:__________

Insured Party's Name:__________________________ Relationship:___________________

SECONDARY INSURANCE

Secondary Insurance: ____________________________________ Phone #:________________

Group #:_____________ Insurance ID#:_____________ Insured Person Date of Birth:__________

Billing Address: ____

Insured Party's Name: _________________________Relationship: ___________________

PHYSICIAN INFORMATION

Primary Care Physician:_______________________________ Clinic:____________________

Referred By: ____ NPI: ____________________
Please print doctor's first and last name

EMPLOYMENT INFORMATION

Full Time_____ Part Time_____ Retired______ Not Employed_____ Seasonal _____

Employer Name:____ Phone #: _______________

Address:____ Occupation:_______________

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Pre Sleep Questionnaire

PATIENT NAME:______________________________ Date:______________________

Height:_______ Weight:_______

1. What time is your usual bedtime / wake-up time at home?
   Bedtime______________AM / PM Wake-up time_____________AM / PM
2. How many hours of sleep did you get last night? _______Hrs.
3. How alert / awake are you today?______________________________________
4. Did you take any naps?_________________________How long?______________
5. On a scale of 1 to 10 (1 being wide awake, 10 fighting sleep) how sleepy are you now?________
6. Are you ill, upset, or anxious?____
7. What prescription or non-prescription medication(s) have you taken in the last 24 hours?____
8. Do you take any medications before you go to sleep? ☐ Yes ☐ No If yes, please bring your medications with you.
9. Do you have any allergies? ☐ Yes ☐ No If yes, please explain:______________
   ____
10. How many of the following have you had today?

_____	coffee	_____	beer
_____	tea	_____	wine
_____	soda	_____	mixed drinks
_____	cigarettes		

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Patient Sleep History Questionnaire

Please answer all of the questions and bring with you the night of your sleep study.

Name: ______________________________ Today's Date: ______________

Birthdate: ____________ Gender: Male / Female Age: _____ Ht: ______ Wt: ______

Primary physician: __________________ Referring physician: ___________________

Please describe the difficulties you are having with your sleep:

____

____

____

Sleep

1) Have you been told that you frequently snore loudly in your sleep? ☐ Yes ☐ No
2) Have you been told that you stop breathing during your sleep? ☐ Yes ☐ No
3) Do you have difficulty getting to sleep or staying asleep? ☐ Yes ☐ No
4) After a good night of sleep do you wake up and still feel fatigued? ☐ Yes ☐ No
5) How many times do you awaken on an average night?
   Never 1 - 2 Times 2 - 3 Times 3 Or more times
6) Do you feel sleepy in the daytime? ☐ Yes ☐ No
   If yes, how sleepy? Mildly Moderately Severely
7) Do you work an unusual schedule (swing shift, late night to early morning)? ☐ Yes ☐ No
   If yes, what are your usual work hours? Start: ______ AM / PM End: ______ AM / PM
8) Do you nap in the daytime? ☐ Yes ☐ No
   If yes, how often? ________________
9) Do you have insomnia? ☐ Yes ☐ No
   If yes, how long has this been a problem? ____________________________
10) Have you noted a change in your mood (more depressed, feeling down, irritable, loss of interest in usual activities)? ☐ Yes ☐ No
11) When you try to relax in the evening or sleep at night, do you ever have an unpleasant, rest-less feeling in your legs that is relieved only by walking or movement? ☐ Yes ☐ No
   If yes, how often? ______________________________________

Weight

12) Have you gained or lost weight in the last 1 – 2 years? ☐ Yes ☐ No
   If yes, how much?____________ Gained / Lost

Family History

13) Does anyone in your family have sleep apnea? ☐ Yes ☐ No
14) Does anyone in your family have narcolepsy? ☐ Yes ☐ No

Medical Issues

15) Do you have high blood pressure? ☐ Yes ☐ No
If yes, what blood pressure medication do you take? ____________________
16) Have you had congestive heart failure, heart attack, stroke, or stents placed in your heart? ☐ Yes ☐ No
17) Do you have lung problems, such as asthma or emphysema? ☐ Yes ☐ No
18) Do you take medication for pain? ☐ Yes ☐ No
19) Do you have diabetes? ☐ Yes ☐ No
20) Do you have any neurological problems? ☐ Yes ☐ No
21) Do you have a history of depression / anxiety? ☐ Yes ☐ No
22) Do you have any other medical problems? ☐ Yes ☐ No
If yes, please explain: ____________________
____
____

Surgeries

23) Have you had your tonsils removed? ☐ Yes ☐ No If yes, when? ____________
24) Have you had nose/throat surgery? ☐ Yes ☐ No If yes, when? ____________
25) Please list any other surgeries or operations you have had:

Surgery	Date

Medications

Please list your medications, including over-the-counter medicines, vitamins, or herbs. If you do not know the name please indicate what it is for.

Epworth Sleepiness Scale (On a scale of 0- to 10 (0= none, 10= every night) use the number scale to rate your chances of falling asleep in the following situations.

_____ Sitting and reading
_____ Watching television
_____ As a passenger in a car for one hour
_____ Sitting quietly after lunch (without alcohol)
_____ Driving in a car while stopped for a few minutes in traffic
_____ Sitting inactive in a public place
_____ Lying down to rest in the afternoon
_____ Sitting and speaking to someone

On an average basis how troubled is your sleep by the following: (check mark if it is applicable)

_____ Cannot fall asleep within 30 minutes
_____ Wake up snoring or coughing
_____ Wake up during the night
_____ Wake up to use the bathroom
_____ Wake up with heartburn/acid taste in mouth
_____ Wake up short of breath
_____ Wake up with anxiety or panic
_____ Wake up with a cough
_____ Wake up due to pain/discomfort
_____ Early morning awakening

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RESPONSIBLE PARTY

Name: ______________________ Relationship to Patient: _____________ Date of Birth: ______

Address: ____ Phone #: ___________

Employer & Address: ____ Phone #: ___________

Drivers License #: ___________________ State: ___________

ASSIGNMENT OF BENEFITS

I hereby authorize release of any information, including the diagnosis and records of treatment or examination, rendered to my insurance company or companies. I hereby authorize payment directly to Costal Diagnostic Testing Group, LLC the insurance benefits otherwise payable to me. I understand the responsibility for payment of services provided in this office for myself or dependents are mine.

Initial *I have received a copy of the Notice of the Privacy Policy*______________*Initial*

Patient Signature: ______________________________________ Date: ________________

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Privacy Policy

Reason for a privacy policy
It is our desire to communicate to you that we are taking the new federal Health Insurance Portability and Accountability Act (HIPPA) Laws written to protect the confidentiality of your health information seriously. The changes in the evolution of computer technology used in healthcare have prompted the government to seek a way to standardize and protect the electronic exchange of your health information. **Coastal Diagnostic Testing Group, LLC** respects your privacy; we understand your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes our test results, diagnosis, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatments and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read carefully.

Examples of use and disclosure of protected health information of treatment, payment, and health operations.
For Treatment:
Information obtained by **Coastal Diagnostic Testing Group, LLC** or members of our health care team will be recorded in your medical records and will be used to help decide what care may be right for you. We may also provide information to others providing your care. This will help stay informed about your care.

For Payment:
When we request payments from your health insurance plan, they need information from us about your care. Information provided to health plans may include your diagnosis, procedures performed and recommended care.

For Health Care Operations:
We use your medical records to assess quality and improved service.

☑ We may use and disclose medical records to review qualifications and performance of our health care providers and to train our staff.
☑ We may contact you by telephone, letters, postcards or email to remind you about appointments and give you information about treatment alternatives or other health related benefits and service.
☑ We may use and disclose information to conduct or arrange services, including: accounting, legal, risk management, and insurance services.

Your Health Information Rights

The health and billing records we create and store are property of **Coastal Diagnostic Testing Group, LLC**. The protected health information in it however, generally belongs to you. You have the right to:

- ☑ Receive, read, and ask questions about this notice.
- ☑ Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request, but we will comply with any requests granted.
- ☑ Request and receive from us a paper copy of the most current Notice of Privacy Practice for protected Health Information ("Notice").
- ☑ Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- ☑ Have us review a denial of access to your health information-except in certain circumstances.
- ☑ As us to change your insurance information. You may give us this request in writing or with a telephone call.
- ☑ You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records.
- ☑ When you request, we will give you a list of disclosures of your health information. The list will not include disclosure to third-party payers. You may receive this information with charge once every 12 months. We will notify you of the costs involved if you request is more than once in a 12-month period.

Our Responsibilities

We are required to:

- ☑ Keep your protected health information private.
- ☑ Give you this notice.
- ☑ Follow the terms of this notice.

To ask for help or complain:

If you have any questions, want more information, or want to report a problem about the handling of your protected health, you may contact:

Office Manager
Coastal Diagnostic Testing Group, LLC
475 Elmira Avenue SE Suite 101
Bandon, OR 97411-7405
541-329-0099

If you believe that your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Chief Executive Officer at our office. You may also file a complaint to the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other disclosure and uses of the Protected Health Information and healthcare operations include:
Notification of Family and others.
If you request, we may release information about you to a friend or family member who is involved in your sleep disorder treatment. We may tell your family or friend your condition, and that you are in a hospital. In addition, we may disclose health information about you to assist in a disaster relief. You have the right to object to this use, or disclosure of your information. If you object, we will not disclose it.