midway
Sleep Lab

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
ACCREDITED
MEMBER CENTER

FINANCIAL AUTHORIZATION & RELEASE FORM

I hereby acknowledge that I am receiving or am scheduled to receive health care services, including, but not limited APAP and HST related services. I understand that payments for the services rendered on my behalf are my sole responsibility. I hereby authorize Midway Sleep Lab LLC, Abraham Ishaaya MD, A Professional Corporation, or designated subsidiaries or agents (collectively, “Company”) to:

1. Bill my insurance provider and receive payment directly for all services rendered on my behalf. Should my insurance send payment for these services to me, I will pay the entire payment received by me to Company. In the event my insurance company pays for the APAP on a “rental” basis, I agree to be responsible for payment of the APAP.
2. Bill me for any amounts not paid by my insurance provider. These include, but not limited to, co-payments, deductibles, and non-covered services. I understand that these are determined by my insurance provider and policy and authorize Company to charge my credit card for such amounts. I agree to be responsible for all resulting balances and release Company from any liability relating to any such balances.

Accepting Assignment

I understand that Company will accept assignment for all covered services provided. Assignment is defined as “Reasonable and Customary Charge” for covered services. These are established by the insurance provider for the geographical area in which the service is provided.

Liability Release

I authorize access to all of my insurance information and medical records necessary for billing the related health care services. I hereby give permission to release any medical information or insurance information in order to file any insurance claims. I release Company from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on me or my dependent to be paid directly to the provider and payment for services in my or my dependents’ behalf are my sole responsibility. I understand that a separate bill for interpretation may be sent from the interpreting physician.

I certify that I have read and understand the above information, my responsibilities and I have access to a copy of this form.

Print Patient Name: ____

Signature of Patient or Responsible Representative: ___________________________

Date: _____________________________ Time: _______________________________

If a representative is signing for the patient, list the relationship and print name below.

_________________________________ _____________________________________
(Relationship to patient) (Print Name

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Name: ______________________________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
Even if you have not done some of these activities recently, try to think how you would react.
Use the following scale to choose the most appropriate number rating for each situation.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

1.	Sitting and reading
2.	Watching TV
3.	Sitting, inactive in a public place
4.	As a passenger in a car for an hour without a break
5.	Lying down to rest in the afternoon when circumstances permit
6.	Sitting and talking to someone
7.	Sitting quietly after lunch (without alcohol)
8.	In a car, while stopped for a few minutes in traffic

Berlin Questionnaire

Please check the box that best answers each question for all three Categories.

CATEGORY I

1. Do you snore?
☐ Yes ☐ No ☐ Don't know

2. How loud is your snoring?
☐ As loud as breathing ☐ As loud as talking ☐ Louder than talking ☐ Can be heard in next room

3. How frequently do you snore?
☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

4. Does your snoring bother other people?
☐ Yes ☐ No ☐ Don't know

5. Has anyone ever noticed you stop breathing in your sleep?
☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

CATEGORY II

6. How often do you feel tired after sleeping?
☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

7. Do you feel tired during your waking time?
☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

8. How often do you nod off or fall asleep while driving?
☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

CAT. III

9. Do you have high blood pressure?
☐ Yes ☐ No ☐ Don't know

10. Is your BMI (Body Mass Index) over 30?
☐ Yes ☐ No ☐ Don't know

FOR OFFICE USE ONLY

Category I _____ Category III _____
Category II _____ ___ High | ___ Low

HEALTH & SLEEP HISTORY QUESTIONNAIRE

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Name: ____ **Date:** ________________

Birthdate: _____________ **Age:** _______ **Occupation:** _________________________

Gender: ________ **Height:** ________ **Weight:** ___________ **Weight *Last Year:*** _________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

What is (are) your **current, main** sleep complaint(s)? Check only the ones that apply.

☐ Loud snoring ☐ Pauses in breathing while asleep ☐ Awaken gasping for breath
☐ Awaken from sleep still tired ☐ Difficulty falling asleep ☐ Difficulty staying asleep
☐ Awaken too early ☐ Excessive movement in sleep ☐ Excessive daytime sleepiness

Previous Sleep Evaluations & Treatment - *Answer all that Apply*

(If this is your first evaluation, please skip to the next section)

1. My last sleep evaluation was *(check one)*:
   _____less than 6 months ago _____less than 1 year ago _____ years ago _____ Never

2. I was diagnosed with: ____

3. I use a CPAP or Bi-Level device *(pick one)*: ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁYESÁÁÁÁÁÁÁÁÁÁÁÁÁÞO

4. I have had surgery to treat a sleep disorder *(pick one)*: ÁÁÁÁÁÁYES ÁÁÁÁÁÁÁÁÁÞO
   If yes, what type of surgery was performed? ____________________

Current Medication List

Please list all current medications you take, prescribed and OTC (Over-the-Counter) below, including vitamins & supplements. Attach separate page if needed.

MEDICATION	REASON FOR TAKING	DOSAGE

Do you use supplemental oxygen? ☐ YES ☐ NO
If yes, when & what amount? ☐ PRN ☐ 24/7 at ______ l/min

Allergies

Please list known allergies: ____

____

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Patient Medical History

Please answer all questions to the best of your ability, checking either YES or NO.

Have you ever had any of the following medical conditions?

Condition			Condition		
Tuberculosis	☐ YES	☐ NO	Lung Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Diabetes (Blood Sugar High / Low)	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Stomach Disease	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Intestinal Disease	☐ YES	☐ NO
Other Heart Disease	☐ YES	☐ NO	Peptic Ulcer	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Enlarged Tonsils/Adenoids	☐ YES	☐ NO	Depression/Anxiety	☐ YES	☐ NO
Deviated Nasal Septum / Polyps	☐ YES	☐ NO	Bipolar Disorder	☐ YES	☐ NO
COPD (Emphysema/Chronic Bronchitis)	☐ YES	☐ NO	Glaucoma	☐ YES	☐ NO

Sleep & Breathing

Question			
1. Do you snore?	☐ Never	☐ Sometimes	☐ Always
2. Does your snoring wake you up?	☐ Never	☐ Sometimes	☐ Always
3. Is your snoring broken by hesitations, gasps and snorts?	☐ Never	☐ Sometimes	☐ Always
4. Are the hesitations long enough to frighten your sleep partner?	☐ Never	☐ Sometimes	☐ Always
5. Has your snoring driven your bed partner from the bedroom?	☐ Never	☐ Sometimes	☐ Always
6. Do you awaken with a dry mouth?	☐ Never	☐ Sometimes	☐ Always
7. Do you awaken with headaches?	☐ Never	☐ Sometimes	☐ Always
8. Do you awaken choking or gasping for air?	☐ Never	☐ Sometimes	☐ Always
9. Have you ever fallen asleep while driving or stopped in traffic?	☐ Never	☐ Sometimes	☐ Always
10. When you wake, are your sinuses stuffed or clogged up?	☐ Never	☐ Sometimes	☐ Always
11. Do you take naps during the day?	☐ Never	☐ Sometimes	☐ Always
12. Do you wake up feeling your heart pounding or racing?	☐ Never	☐ Sometimes	☐ Always

Sleep Disturbances

Question			
13. Do you experience unpleasant leg sensations at bedtime?	☐ Never	☐ Sometimes	☐ Always
14. Do you kick or jerk your legs and/or arms during sleep?	☐ Never	☐ Sometimes	☐ Always
15. Do you have sweats or awaken from sleep feeling flushed?	☐ Never	☐ Sometimes	☐ Always
16. Do you awaken with a bitter or acid taste in your mouth?	☐ Never	☐ Sometimes	☐ Always
17. Do you frequently have nightmares or vivid dreams?	☐ Never	☐ Sometimes	☐ Always
18. Do you grind your teeth or have bitten your cheek during sleep?	☐ Never	☐ Sometimes	☐ Always
19. Have you ever walked or talked in your sleep?	☐ Never	☐ Sometimes	☐ Always
20. Have you ever felt unable to move after awakening?	☐ Never	☐ Sometimes	☐ Always
21. Have you ever seen or felt things from your dreams after awakening?	☐ Never	☐ Sometimes	☐ Always
22. Have you ever experienced weakness when laughing or angry?	☐ Never	☐ Sometimes	☐ Always
23. Have you ever had unusual movements or behaviors during sleep?	☐ Never	☐ Sometimes	☐ Always

Please describe: ______________________________

Question			
24. Outside of childhood, have you ever wet the bed?	☐ Never	☐ Sometimes	☐ Always
25. Do you sleep with the TV on?	☐ Never	☐ Sometimes	☐ Always
If yes, do you use a sleep timer?	☐ Never	☐ Sometimes	☐ Always
26. Is your sleep disturbed by a household member?	☐ Never	☐ Sometimes	☐ Always

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Social Habits

1. Do you use tobacco (now or past)ÑÁÁÁÇ*Check types)* ÁÁSmoking or ÁÁÁChewing ☐ YES ☐ NO
   a) If yes now, how many per day and for how many years: ______________________
   b) If yes now, what time of day did you last smoke: ______________________
   c) If quit, when did you quit: ______________________
   d) If quit, how many per day and for how long: ______________________
2. Do you drink alcohol (includes beer, wine & liquor)? ☐ YES ☐ NO
   a) If yes, how many drinks - per *(pick frequency)*: ______ per: day week month
   b) If yes, when was your last drink (date & time): ______________________
   c) If quit, when did you quit: ______________________
3. Do you drink/take caffeine (includes caffeine pills, energy drinks, coffee, tea & soda)? ☐ YES ☐ NO
   a) How many caffeinated beverages/pills per day: ______________________
4. Do you use illicit/recreational drugs? ☐ YES ☐ NO
   a) Marijuana ☐ YES ☐ NO If yes, how often ________; last used ________
   b) Cocaine/Crack/Amphetamine ☐ YES ☐ NO If yes, how often ________; last used ________
   c) Heroin/Morphine/Methadone ☐ YES ☐ NO If yes, how often ________; last used ________
   d) LSD/Mushrooms/PCP ☐ YES ☐ NO If yes, how often ________; last used ________
   e) Other Uppers/Downers ☐ YES ☐ NO If yes, how often ________; last used ________