Zeeba Sleep Center

2481 Professional Court
Las Vegas, NV 89128
702-242-1562

Your appointment is scheduled for _____@_____

On the day of your study:

- ★ Please do not bring any valuables with you except the copay and deductible required by your insurance. This should be discussed with you prior to your appointment. If you do not fully understand the amount you will be responsible for, please call the number above.
- ★ Arrive at your set appointment time with your hair dry, washed, free of gels, mousse, or sprays. The front door will be open for you. You may want to bring a book to read.
- ★ Your face should be free of makeup, lotions, after-shave, and be clean shaven.
- ★ Regardless of your routine at home, we discourage sleeping nude here in the office.
- ★ We ask that you make every effort not to nap on the day of your study. This is especially important in the late afternoon and early evening prior to arriving at the sleep center.
- ★ Try to keep to your normal daily routine as much as possible. You may eat the way you would on any other day, but please refrain from having any caffeine or alcohol after 12:00 noon. These products include: chocolate, coffee, soda, tea, etc. You should take your medications as you normally do unless otherwise instructed by your doctor.
- ★ Please bring a list of your current medications. If you take any prescriptions just prior to bed, please bring them along.
- ★ Please be aware that if you do not show up for your appointment, or if you cancel your appointment with less than 48 hours notice, a cancellation fee of $200 will be charged. The reason for this fee is that a specialized sleep technologist must be scheduled to come to monitor the study. This technologist will be paid whether you are here or not.
- ★ On the day of your study, please make arrangements to bring in your copay/deductible amount. This may also be paid prior to your study by calling the number above.

Once you have arrived:

- ★ You will be introduced to all the features of our sleep facility.
- ★ You will be asked to complete some paperwork and pay your portion of the cost of the sleep study. Failure to do this may result in rescheduling the study.
- ★ Next, you will change into your sleep clothes if you are not already dressed for bed.
- ★ Your sleep technologist will then explain the procedure and prepare you for bed. There will be several wires or electrodes placed on your head, face, neck, chest, legs, and hand. They will be secured with tape, gauze, or cotton. This whole procedure will take about one hour.
- ★ Your sleep study should take between 6-7 hours. Once you awaken in the morning, you may leave the facility.
- ★ We will contact you with the results of your study and the next steps you should take. These may include a more intricate sleep study called a Titration study, a follow up appointment to go over the results, etc.
- ★ If you have any unanswered questions, please contact our office at the number above.

Comprehensive Medical History

Patient Name: _____ DOB: _____ Age: _____

Main Complaint: _____

Current Medications:

Name of Medication	Dose Strength	Dose Frequency	Prescribed By

Please let a staff member know if you require additional space for medications taken.

Current and/or past major illnesses or medical problems:

Medical Condition	Approximate date diagnosed	Comments

Past surgeries:

Description	Approximate date of surgery	Comments

Allergies: _____

Do/Did you smoke? Y or N If yes, _____ packs per day. If you quit, _____ years ago.

Do you drink alcohol? If yes, type _____ How much? _____ How Often? _____

Family History (check all that apply):

Description	Mother	Father	Sister/Brother
Heart Disease			
Blood Pressure Problems			
Stroke			
Cancer			
Diabetes			
Other_____			

Circle where appropriate: Are you experiencing any of the following?

Fever---chills---tiredness---vision problems---swollen glands---chest pain---difficulty breathing---palpitations---lightheadedness---passing out---ankle swelling---coughing---wheezing---weight loss---weight gain---change in bowel habits---change in bladder control---change in moles---new skin lesions---joint pain---joint stiffness---swollen joints---headache---memory loss---numbness---increased thirst---increased urination---cold intolerance---heat intolerance---irregular periods---missed periods---sexual problems

If not circled, negative.

Please list the most current date for the following:

Pneumonia shot: _____ Tetanus Shot: _____ Mammogram: _____

Colonoscopy: _____ Bone Density: _____ Pap or Prostate exam: _____

Zeeba Sleep Center
Sleep Questionnaire

Name:			Date:	
Ht:	**Wt:**	**Sex:**	Marital Status:	Date of Birth:
Collar Size:	**inches**			
Daytime Phone:			Cell Number:	
			Email:	
Primary Care Physician:				
Emergency Contact and Number:				
Who referred you?				

Please answer Yes or No and comment if needed

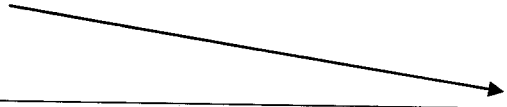
	Y	N	Comment
Moderate to Loud Snoring			
Have been told you stop breathing during sleep			
Do you get sleepy during the day			
Morning Headaches			
Do you feel rested when you wake up in the morning			
Do you ever wake up gasping or choking			
Have you ever falling asleep while driving			
Have you ever had an overnight sleep study, if yes, where and when. What was the result			
Have you ever been on CPAP (for sleep apnea). If yes when.			
High Blood Pressure			
Heart problems or a Stroke in the past			
Do you suffer from a Mood Disorder e.g. Depression			
Have you gained more than 30 pounds in the last 2 years			
Have you ever been diagnosed with Insomnia			

What time do you lay down to go to sleep at night		**What time to you get out of bed in the morning**	
How many hours of sleep do you think you average per night		**How long does it take you on average to fall asleep**	

Zeeba Sleep Center
Sleep Questionnaire

Epworth Sleepiness Questionnaire: Please answer the following questions based on this scale:

Would never fall asleep	0
Slight chance of dozing	1
Moderate chance of dozing	2
High chance of dozing	3



While reading	
While watching TV	
Sitting in a public place, like a moving theatre or waiting room	
Driving a car, stopped at a traffic light	
As a passenger in a car for an hour without a break	
Sitting and talking to someone	
Lying down to rest, when circumstance permit	
During a quite time after lunch, without alcohol	
Total:	

	Y	N	Comment
Do you work swing shift, night shift or graveyard			
Has your sleep routine changed in the last 6 months			
Do you feel your sleep quality and quantity of sleep is less than optimal			
Do you have problems falling asleep, due to racing thoughts or anxiety			
Do you wake up frequently at night and have difficulty getting back to sleep			
Do you wake up more than 2 times per night to urinate			
Do you use alcohol at night to help you get to sleep			
Do you use sleep aids more than 3 times per month – if so what do you use			
<u>Do you have any of the following:</u>	**Y**	**N**	
Strange sensation in the legs while trying to fall asleep			
Urge to move the legs when laying down or sitting quietly, that is worse at night			
A discomfort in the legs at rest that is relieved my moving the legs			
Partner reports a lot of leg movement while sleeping			
Sleep walking in the past or currently			
Unintentional night eating – i.e. after going to bed			
Thrashing around in bed, thrown off the covers or fallen out of bed			
Injured or kicked a bed partner			
Injured yourself while sleeping			
Acted out dreams			

Zeeba Sleep Center
Sleep Questionnaire

	Y	N	
Woken up from sleep unable to move your body – a sensation of being paralysed			
Uncontrollable 'sleep attacks' – fallen asleep during the day in strange situations			
Wake up refreshed but get sleepy again 2 – 3 hours after awakening			
If you nap during the day, do you usually feel refreshed after the nap			
*****Read the following question very carefully:*****	**Y**	**N**	
Have you ever had episodes of sudden weakness, of the neck muscles, arms or legs, that occur specifically with strong emotions, like laughing, crying or surprise. The sudden weakness MUST be directly associated with the emotion and must be quite obvious. If this has occurred it must have seemed very unusual and concerning.			
Vivid dreams while trying to get to sleep			

List of Medications

Name of Medication	Dose

Other Medical Issues	Y	N	Comments
Seizures			
Irregular heart beat or atrial fibrillation			
Anxiety or Depression			
Chronic pain or fibromyalgia			
COPD or emphysema			
Thyroid problems			
Heart attack, stroke or heart failure			

Zeeba Sleep Center
Sleep Questionnaire

Bed Partner or Sleep Observer Questionnaire

Check any of the following behaviors that you have observed the patient do while he\she is asleep.

	Y	Comment
Moderate to Loud Snoring		
Pauses in breathing, lasting more than 5 seconds		
Twitching of the legs or feet during sleep		
Teeth grinding		
Sleep talking		
Sleep walking		
Sleep eating		
Sitting up in bed, but not awake		
Head rocking or banging		
Kicking of legs, or thrashing of arms while sleeping		
Becoming very rigid or shaking		
Other unusual behaviors in bed, with no morning recall of events		

Describe the behavior(s) checked above in more detail if needed:

Beck Inventory

Name:_____ **Date:**_____

On this questionnaire are groups of statements. Please read each group of statements carefully. Pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY. Circle the number beside the statement you chose. If several statements seem to apply equally well, circle each one. Be sure to read all of the statements in each group before making your choice.

1. 0 I do not feel sad
   1 I feel sad
   2 I am sad all the time and I can't snap out of it
   3 I am so sad or unhappy that I can't stand it

2. 0 I am not particularly discouraged about the future
   1 I feel discouraged about the future
   2 I feel I have nothing to look forward to
   3 I feel the future is hopeless and that things can't improve

3. 0 I do not feel like a failure
   1 I feel I have failed more than the average person
   2 As I look back on my life, all I see are a lot of failures
   3 I feel I am a complete failure as a person

4. 0 I get as much satisfaction out of things as I used to
   1 I Don't enjoy things the way I used to
   2 I don't get real satisfaction out of anything anymore
   3 I am dissatisfied or bored with everything

5. 0 I don't feel particularly guilty
   1 I feel guilty a good part of the time
   2 I feel quite guilty most of the time
   3 I feel guilty all the time

6. 0 I don't feel I am being punished
   1 I feel I may be punished
   2 I expect to be punished
   3 I feel I am being punished

7. 0 I don't feel disappointed in myself
   1 I am disappointed in myself
   2 I am disgusted with myself
   3 I hate myself

8. 0 I don't feel I am any worse than anybody else
   1 I am critical of myself for my weaknesses or mistakes
   2 I blame myself all the time for my faults
   3 I blame myself for everything bad that happens

9. 0 I don't have any thoughts of killing myself
   1 I have thoughts of killing myself, but would not carry them out
   2 I would like to kill myself
   3 I would kill myself if I had the chance

10. 0 I don't cry any more than usual
    1 I cry more now than I used to
    2 I cry all the time now
    3 I used to be able to cry, but now I can't cry even though I want to

11. 0 I am no more irritated now than I ever am
    1 I get annoyed or irritated more easily than I used to
    2 I feel irritated all the time now
    3 I don't get irritated at all by the things that used to irritate me

12. 0 I have not lost interest in other people
    1 I am less interested in other people than I used to be
    2 I have lost most of my interest in other people
    3 I have lost all of my interest in other people

13. 0 I make decisions as well as I ever could
    1 I put off making decisions more than I used to
    2 I have greater difficulty in making decisions than before
    3 I can't make decisions at all anymore

14. 0 I don't feel that I look any worse than I used to
    1 I am worried that I am looking old or unattractive
    2 I feel that there are permanent changes in my appearance that make me look unattractive
    3 I believe that I look ugly

15. 0 I can work about as well as before
    1 It takes extra effort to get started at doing something
    2 I have to push myself very hard to do anything
    3 I can't do any work at all

16. 0 I can sleep as well as usual
    1 I don't sleep as well as I used to
    2 I wake up 1-2 hours earlier than usual and have trouble returning to sleep
    3 I wake up several hours earlier than I used to and can't return to sleep

17. 0 I don't get more tired than usual
    1 I get tired more easily than I used to
    2 I get tired from doing almost anything
    3 I am too tired to do anything

18. 0 My appetite is no worse than usual
    1 My appetite is not as good as it used to be
    2 My appetite is much worse now
    3 I have no appetite at all anymore

19. 0 I haven't lost much weight, if any, lately
    1 I have lost more than 5 pounds
    2 I have lost more than 10 pounds
    3 I have lost more than 15 pounds
    I have purposely been trying to lose weight by eating less Y or N

20. 0 I am no more worried about my health than usual
    1 I am worried about my physical problems such as aches & pains, upset stomach, or constipation
    2 I am very worried about physical problems and it's hard to think of much else
    3 I am so worried about physical problems that I can't think of anything else

21. 0 I have not noticed any recent changes in my interest in sex
    1 I am less interested in sex than I used to be
    2 I am much less interested in sex now
    3 I have lost interest in sex completely

BDI=

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Financial Policy

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realize that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse **Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Solver, FNP** within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. **We will attempt to obtain these as a courtesy; however, the policy holder must be pro-active in assuring the requirements are met prior to the visit.**

If you have medical insurance, with which we are contracted, we will bill your insurance company. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy: Patient name: _____.
I, _____ (parent /guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

_____ _____
Signature of patient, parent / guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office. **INITALS:** ____
No Show Fees: There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation. **INITALS:** ____
Sleep Study No Show Fees: There is a $200 no-show/late-cancellation fee. All appointments must be cancelled 24hrs prior to your appointment time. Insurance will not cover charges for no-show/late-cancellation. **INTIALS:**

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I _____ give my authorization for Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Velasco, FNP or Zeeba Sleep Center to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Clifford Molin, MD, LTD.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Requested by Law, Public Health issues as requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Clifford Molin, MD, Peter Philander, MD, Stephanie Lehrner, DO, Nikki Velasco, FNP or Zeeba Sleep Center to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____