

Houston Neurology and Sleep Center
Todd J. Swick, MD, PA
Patient Information Sheet

Referring Physician: _____ Address: _____
Physician Phone: _____ Fax: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____
SSN #: _____ Date of Birth: _____ Age: _____ Male / Female (Married: M S D)
Telephone #: H (_____) W (_____) Cell (_____)
Home Address: _____ City, State, Zip: _____
Your Employer: _____ Occupation: _____
Employer Address: _____ City, State, Zip: _____

Spouse Last Name: _____ First Name: _____ Middle Initial: _____
SSN #: _____ Date of Birth: _____ Age: _____
Telephone #: H (_____) W (_____) Cell (_____)
Spouse's Employer: _____ Occupation: _____
Employer Address: _____ City, State, Zip: _____

Emergency Contact Name: _____ Relationship: _____
Telephone #: H (_____) W (_____) Cell (_____)

Insurance Information: PPO HMO POS EPO Medicare Medicaid Other: _____
Primary Insurance Company: _____ Insured Name: _____
Telephone #: _____ ID #: _____ Group #: _____
Secondary Insurance Company: _____ Insured Name: _____
Telephone #: _____ ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS AND RELEASE INFORMATION TO FILE INSURANCE

I hereby authorize Houston Neurology and Sleep Center to receive payment of insurance benefits for the procedures performed and for services provided. I also understand that a photocopy of this authorization can be used and will be valid as my original signature. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Houston Neurology and Sleep Center to release any information to the insurance and or referring physician acquired in the course of my examination or treatment.

Signed (Patient / Responsible Party) Date

WE NEED A COPY OF YOUR INSURANCE CARDS AND YOUR DRIVER LICENSE. Thank you

**HOUSTON NEUROLOGY and SLEEP CONSULTANTS
 THE HOUSTON SLEEP CENTER**

NEW PATIENT HISTORY/SLEEP DISORDERS QUESTIONNAIRE

Date: _____

Name: Last: _____ First: _____ MI: _____ Male/Female

Date of Birth: ____/____/____ Age: _____ Marital Status: _____ Referring Physician: _____

Occupation: _____ Employer: _____

Weight: Current: _____ One Year Ago: _____ Max Weight Ever: _____ Height: _____ Neck Size (if known): _____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits and observations.

GENERAL SLEEP INFORMATION:

What is your sleep problem? _____

How long have you had a sleep problem? _____ Wks; _____ Months; _____ Years

How many nights each week do you have a sleep problem? _____

Do you work night shifts or rotating shifts? Yes/No if yes what are your work hours? _____

What time do you usually go to bed on weekdays? _____ Weekends? _____

Do you wake up during the night? Yes/No. If so how many times? _____ How long are you awake? _____

Do you have difficulty going back to sleep after awakening during the night? _____

What time do you get out of bed in the morning on weekdays? _____ Weekends? _____

Do you feel refreshed when you first get out of bed in the morning? Yes/No/It Depends; _____

Is it difficult to wake up in the morning? Yes/No How many times do you hit the snooze button? _____

Do you take intentional naps during the day? Yes/No/Sometimes How often? _____

What time do you nap? _____ Average length of nap? _____ Is the nap refreshing? _____

Do you consider yourself a morning person/night person/neither (time of the day of maximum energy?) _____

Do you dread getting into bed because you think you will "never" fall asleep? Yes/No If yes how often? _____

AFTER DECIDING TO GO TO SLEEP AT NIGHT:

1. Do you usually have difficulty falling asleep? Yes/No
2. Do you experience pain or physical discomfort at bedtime or during the night? Yes/No
3. Do you feel unable to relax? Yes/No It is physical or mental (circle the appropriate condition)
4. Do your thoughts race (unable to shut your thoughts and/or mind off)? Yes/No
5. Do you have uncomfortable, unusual or restless sensations in your legs (or arms) when you first get into bed? Yes/No
 - a. If so, do you feel the need to get up and move, stretch or walk to relieve the sensation? Yes/No
 - b. If so, does walking, moving or stretching relieve the sensation? Yes/No
 - c. If relieved by movement, do the sensations return when you return to rest or bed? Yes/No
6. Check which of the following techniques or behaviors you use (even occasionally) to help fall asleep (if any):

Medication (prescription or over-the-counter	Baths, Hot tubs, Hot packs, etc.
Biofeedback (including self-hypnosis, tapes, etc.)	Exercise
Relaxation techniques	Food, special drinks (non-alcoholic), vitamins, etc.
Alcohol	Reading
Watching TV or listening to radio	Mental imagery (counting sheep, image projection)

AFTER FALLING ASLEEP:

1. Have you ever been told that you **jerk, twitch or kick** during your sleep? Yes/No
 - a. If so when during the night (approximate time of night) does it occur? _____
 - b. What activities prior to going to sleep make it worse (e.g. alcohol intake, drugs, etc.)? _____
2. Have you ever been told that you **snore**? Yes/No If yes, for how long? _____
3. Have you been told that there are **pauses or stopping of breathing** during your sleep? Yes/No
4. Have you ever awakened **choking and/or gasping for breath** during the night? Yes/No
5. Have you ever experienced **sleep walking or sleep talking**? Yes/No (Circle one or both if appropriate)
 - a. When did it occur? _____ how frequently does it or did it occur? _____
6. Do you **grind your teeth (bruxism)** during sleep? Yes/No if yes, do you wear a "night guard"? Yes/No if yes for how long? _____ weeks/months/ years?
7. Do you experience any "**unusual or abnormal behavior**" during your sleep? Yes/No (thrashing about, striking bedmate, etc)
 - a. If yes, please describe: _____
 - b. Does it bother your bedmate (if applicable) and what if anything is their response? _____
8. Do you experience **nightmares and/or night terrors**? Yes/No How Often? _____
 - a. If yes are there recurring themes? Yes/No Describe: _____
9. Do you wake up during the night to use the restroom? Yes/No If yes how many times? _____
10. Do you wake up with a **dry mouth** during the night or morning? Yes/No If yes, for how long? _____
11. Is your sleep disturbed by any of the following conditions?

Yes	No	Heat, Cold, Light, Noise, Pets, (Circle appropriate condition)
Yes	No	Nasal congestion, stuffiness, or nasal blockage during the night
Yes	No	Asthma and/or shortness of breath while lying flat
Yes	No	Palpitations (racing or awareness of heart beat)
Yes	No	Heartburn, Indigestion, burping
Yes	No	Headache or do you wake up with a headache in the morning?

How likely are you to doze off or fall asleep in the following situation, *in contrast to just feeling tired*? Even if you haven't done some of these activities recently, *think about how they would affect you*. Use the following scale to choose the most appropriate number for each situation:

- 0=Would Never Doze
- 1=Slight Chance of Dozing
- 2=Moderate Chance of Dozing
- 3=High Chance of Dozing

Situation:

		<u>Chance of Dozing:</u>			
		0	1	2	3
1. Sitting and reading	0	1	2	3	
2. Watching television	0	1	2	3	
3. Sitting inactive in a public place (e.g., theater or meeting)	0	1	2	3	
4. As a passenger in a car for an hour without a break	0	1	2	3	
5. Lying down to rest in the afternoon	0	1	2	3	
6. Sitting and talking to someone	0	1	2	3	
7. Sitting quietly after lunch (when you've had <u>NO</u> alcohol)	0	1	2	3	
8. In a car, while stopped in traffic	0	1	2	3	
					Total: _____

	Never	Sometimes	Often	Always
1. Do you get sleepy or fall asleep while driving?				
2. Do you get sleepy or fall asleep at work or school?				
3. Do you experience <i>unintentional</i> episodes of sleep?				
5. Do you experience periods of muscle weakness or loss of muscle control <i>with laughter or excitement</i> ?				
6. Do you experience vivid dreams when <i>falling</i> asleep?				
7. Do you ever experience a feeling of being paralyzed (unable to move) when <i>falling</i> asleep?				

How would you rate your overall daytime sleepiness? None Mild Moderate Severe

Are you allergic to any medications? Yes/No If yes which ones? _____

GENERAL HISTORY:

1. Have you had any recent problems with memory and/or concentration? _____
If yes explain: _____

2. Have you had any recent changes in your mood? Such as mood swings (exaggerated highs and/or lows) or increased irritability lately? _____ If yes, explain: _____

3. Are you under significant stress or pressures lately? _____
If yes, explain: _____

4. Do you suffer from depression and/or anxiety (circle appropriate condition) now or within the past 3 years? _____
If yes, explain: _____

5. Do you have any problems in terms of sexual relations (lack of desire, impotency, pain with intercourse, premature ejaculation, etc)? _____

6. Do you travel on a frequent basis (crossing 3 or more time zones per trip) Yes/No.? Does this travel affect your sleep/wake schedule and daytime functioning (in either your target destination or upon your return home)? _____

7. How did you hear about us? Physician Referral/ Friend/ Relative/ Web Page/Internet Search/ Billboard or saw an advertisement in what publication: _____

INFECTION CONTROL QUESTIONNAIRE

NAME: _____

DATE: _____

In order to protect all of our patients, including yourself please review the list below and complete this brief questionnaire.

Have you had yourself or been in contact with anyone that had the below diseases over the past 60 days?

_____yes _____no. If you answered YES, please circle the ones that you were exposed to. Thank you for your cooperation in completing our Infection Control Questionnaire.

DISEASES USUALLY CONSIDERED REPORTABLE:

- Aids
- Amoebiasis
- Anthrax
- Botulism
- Campyrobactra
- Chancroid
- Chickenpox (Varicella)
- Chlamydia
- Cholera
- Influenza
- Leprosy (Hansen's Disease)
- Leptospirosis
- Lyme's Disease
- Malaria
- Measles (Rubeola)
- Meningitis (Aseptic)
- Meningitis (Bacterial)
- Mumps
- Non-gonococcal Urethritis
- Pertussis (whooping cough)
- Plague
- Poliomyelitis
- Psittacosis (Ornithosis)
- Rabies
- Reyes Syndrome
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Salmonella Infections
- Shigellios
- Smallpox
- Syphilis
- Tetanus
- Toxic Shock Syndrome
- Trichinosis
- Tuberculosis

Neurology and Sleep Medicine Consultants of Houston

"Improving the quality of life by improving the quality of sleep"

Todd J. Swick, MD, FAAN, FAASM

Eric A. Bell, Psy. D., FAASM

Sarah L. Aguilar, RN, MSN, FNP-C

NOTICE TO ALL PATIENTS

This is to inform you that Dr. Todd Swick, The Medical Director of The Houston Sleep Center is also an owner of Todd J. Swick, M.D., P.A. d/b/a Sleep Medicine Consultants of Houston and American Sleep Resources d/b/a Sleep Resources of Houston (SRH). You are under **NO** obligation to have your sleep study performed at the Houston Sleep Center and additionally you are under **NO** obligation to have your sleep related DME (CPAP, Bi-Level PAP, masks, hoses, etc) supplied by SRH.

The decision as to where your sleep study is performed and/or from whom your sleep related DME is supplied is yours. If you would like alternative venues please let us know and we will certainly accommodate you.

Last Name: _____ **First Name:** _____ ; **Middle Initial:** _____

Parent's Name if patient is under age 18. _____

Signature

Date

Neurology and Sleep Medicine Consultants of Houston

"Improving the quality of life by improving the quality of sleep"

Todd J. Swick, MD, FAAN, FAASM

Eric A. Bell, Psy. D., FAASM

Sarah L. Aguilar, RN, MSN, FNP-C

Houston Neurology & Sleep Center

Todd J. Swick, M.D. , P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have read and reviewed a copy of Houston Neurology & Sleep Center's Notice of Privacy Practice. This Notice describes how Houston Neurology & Sleep Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my Healthcare information, and rights I may have regarding my protected health information.

Signature of Patient, or Personal Representative

Date

If Personal Representative, relationship to Patient

**7500 San Felipe, Suite 525 • Houston, Texas 77063
(713) 465-9282 Office • (713) 465-9248 Fax**

**21703 Kingsland Blvd., Suite 101 • Katy, Texas 77450
(832) 200-1273 Office • (832) 200-1278 Fax**

21212 Northwest Fwy, Suite 385 • Cypress, Texas 77429 (832) 678-2971 Office • (281) 640-8954 Fax

Houston Neurology & Sleep Center

Dear Valued Patient:

~~Thank you for choosing us to participate in your health care. Our main concern is that you~~ receive the proper and optimal treatment. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy in addition to completing our patient information form. If you have any questions or concerns about our financial policy, please do not hesitate to contact the office.

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, AMERICAN EXPRESS, VISA, MASTERCARD, DISCOVER CARD AND PERSONAL CHECKS.

In **special instances**, we may file your insurance for you.

1. We will file your insurance if you are a member of an insurance plan with which we are contracted. We will make every attempt to verify coverage prior to your visit. **FIXED COPAYS, DEDUCTIBLES, AND NON-COVERED SERVICES WILL BE COLLECTED AT THE TIME OF CHECK IN.** Inability to make payment at the time may require us to reschedule your appointment.
2. **MEDICARE PATIENTS:** It can be considered Medicare fraud to waive deductibles and co-payments. Therefore, you will be asked to pay these amounts at the time the service is rendered.
3. If your insurance plan requires you to have a referral to see us, it is your responsibility, **not ours**, to ensure that the referral is in our office no later than the day of your appointment. You will need to hand-carry this to us on the day of your appointment, you may also fax us a copy prior to your appointment.

In the event that you arrive in our office without a valid referral, you have the following options:

- a. Reschedule your appointment to allow you time to obtain the referral.
- b. You may call your physician to obtain the referral. If it can be faxed to us within 30 minutes will we work you into the schedule. Verbal approvals are not sufficient.

- c. You can be seen as a **fee-for-service** patient for this visit. If you elect this option, you must pay for our full billed charges at the time of service and your insurance company **will not** reimburse you for this visit.

RETURNED CHECKS will incur a \$50.00 fee. The amount of the check plus fee must be paid within ten (10) days of notification via either mail or telephone to prevent further action. **WE DO PROSECUTE THEFT BY CHECK.** Payment will be by money order, cash, or credit card. No partial payments will be accepted. Once a check is returned on your account, we will no longer be able to accept personal checks as payment.

MISSED APPOINTMENTS

Physician appointments are subject to a \$50.00 missed appointment charge. These charges are not covered by your insurance company.

ACCOUNTS TURNED OVER FOR COLLECTION

1. Should my account be turned over for collection, I agree to pay any and all applicable collection agency fees in addition to my principle balance.
2. And, if the account is referred for litigation, additional attorney's fees will be accessed in addition to the principal balance.

The collection agency that we use **DOES** report bad debt to the three national credit bureaus. You may also be given notice legally dismissing you from our practice and asked to find another physician.

Situations do occur that result in overpayments on your account. When overpayments are identified your account will be audited to determine if the overpayment was made by you or the insurance company. Overpayments made by the insurance company will be reimbursed directly to them by us. If there is an overpayment due you, our policy is to apply this overpayment to future visits. Refunds will not be processed until the claim has cleared for the dates of service involved. Special situations warranting a refund check will normally be processed approximately 30 days after final verification.

We understand that temporary financial problems may affect your timely payments of your balances. We encourage you to communicate such problems with our office, so that your account can be properly managed. Again, thank you for choosing us as your health provider. We appreciate your trust in us and we look forward to serving you.

Patient Signature/Responsible Party Signature

Date