The Houston Sleep Center

Accredited by The American Academy of Sleep Medicine

MEMBER CENTER

Todd J. Swick, M.D.
Medical Director
Diplomate, American Board of Sleep Medicine

Welcome to the Houston Sleep Center!

Your procedure has been scheduled for **9:00PM** on: ______________________________
Please arrive on time. If you find you will be a few minutes late, please call to let us know before 5:00PM on the day of your study. Your testing requires an overnight stay at our facility. Most patients leave our center before 7:00AM the next day.

Please note:

This appointment time has been reserved specifically for you. Since your procedure is a highly specialized test scheduled by appointment only, it is imperative for you to keep your appointment time. If, due to an emergency reason, you are unable to keep your appointment, you must contact us ***24 weekday hours PRIOR*** to your appointment; otherwise a $150 fee will be assessed. This is a fee that you are personally responsible for and is not covered by your insurance. Thank you for your understanding and cooperation.

We will hold your appointment time for 30 minutes. If you have not contacted us within this time, your appointment may be rescheduled and a $150 fee assessed.

What to expect:

When you arrive, a member of our staff will greet you, show you your room, and begin explaining the testing process to you. In an effort to make your stay with us a pleasant experience, we provide a comfortable, hotel-like room; bathrooms with showers; and a phone in each room for local and personal use. Our facility consists of six bedrooms in which they are all decorated in a different theme. The themes include: The Longhorn, The Hamptons, Venice, Nautical, Oriental, and Safari. You may be provided with educational videos on sleep-related issues such as snoring and obstructive sleep apnea including discussions on treatment options such as Nasal PAP (Continuous Positive Airway Pressure).

Entering the building for your evening study:

The building has a 24 hour security service available for your convenience. If you would like for the security guard to escort you in, please call (713) 539-2170.
You will be parking in the parking garage of the building. Please park in a space for visitors or that is not marked reserved. Enter the building through the glass door from the garage. The doors are remained locked in the evening, therefore you will have to contact our office using the key pad. **Press # 45** to reach our office. Please state your name so the technician can identify you as a patient and open the door. When entering the building, take the elevator to the 5th floor and we are Suite 550, the last suite to the right when exiting the elevator.

***NOTE: If you have had any recent illnesses such as bronchitis, strep throat, or sinus infection, please contact our office and speak with the Clinical Director, Leslie Ruoff. Such an illness may cause stuffiness, irritability, and inability to sleep resulting in a poor outcome of your procedure. Thank you.**

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Q: Can I drink alcohol and caffeinated beverages before coming to the Sleep Center?
A: Please do not drink any alcoholic beverages on the day you come in to the Sleep Center. Alcohol can influence the quality and type of your sleep. Also – it is very important not to have any caffeinated beverages at lest 6 hours prior to your sleep study.

Q: What should I bring with me to the Sleep Center?
A: Bring any articles you usually use to prepare for bed, including toiletries such as toothpaste and toothbrush, shampoo, or anything else you may need. A shower is available for your use in the morning, but you will want to bring your own towel and shampoo.

Q: Can I get up during the night to use the restroom?
A: If you need to get up for any reason during the night, you may call the technician on duty at any time. It is not difficult to detach you from the recording equipment, and you should not hesitate to call us. However, you should not attempt to get out of bed on your own until the technician has detached you from the recording equipment.

Q: Is it all right to take my medications?
A: Unless otherwise instructed by your physician, take all of your usual medications. Make a list of the medications you have taken on the day of your evaluation. If you take any prescribed medications around bedtime, it is important that you bring these with you to the Sleep Center or take them before you leave home. Medications will not be available at the center. Please bring the list of medications with you when you arrive for your test. DISCONTINUE ALL SLEEPING AID MEDICATION AT LEAST ONE WEEK PRIOR TO THE TEST. Sleeping pills will NOT be given to you for the test. If you have any questions regarding medications, please call our office.

Q: What should I wear to sleep during my stay at the Sleep Center?
A: Feel free to sleep in whatever clothing you usually wear to bed at home. However, you should avoid tight-fitting sleep-wear made of delicate fabrics. Two piece apparel – a top with a separate bottom – is ideal. Gym shorts and T-shirts are fine. If you are cold natured please feel free to bring something warm to sleep in.

Q: Can I use lotions or moisturizers on my skin or hair before the evaluation? What about nail polish?
A: Please avoid wearing moisturizers on your skin of hair to the Sleep Center since these may interfere with the application of the recording electrodes. It is important that your hair and skin be as free of lotions, hairsprays, and moisturizers as possible. Please remove all braids. Remove nail polish and artificial nails from at least one of your index fingers.

Q: Is it all right to bring food it the Sleep Center?
A: If you ordinarily eat a snack before going to bed, a refrigerator is available for your use. Please do not eat heavy or spicy foods immediately before bed since this may cause you to have disturbed sleep.

Q: Should I change my bed time and arousal time prior to my sleep evaluation?
A: It is important to keep your normal sleep schedule and habits prior to your nighttime evaluation. It is especially important to sleep your normal amount on the night before your evaluation because changes in your normal sleep pattern may influence the results of your test.

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

Patient Information Sheet

Referring Physician: ______________________ Address: ______________________

PhysicianPhone: ______________________ 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

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Consent to Perform Sleep Studies (Polysomnography, MSLT's, Extended EEG's, etc.)

An overnight sleep study or polysomnogram is a recording of brain waves (EEG), eye movements, muscle activity from the chin, the ribs, and the lower leg, cardiac activity, respiratory activity, and blood oxygen concentration during a regular night of sleep. A great deal can be learned from a sleep study, including the quantity and quality of sleep obtained, as well as abnormal snoring patterns, respiratory activity, cardiac activity, and muscle activity. Unusual or abnormal brain activity in sleep such as seizure patterns may also be obtained from a patient. From such results, doctors are able to make accurate diagnoses of sleep disorders and to recommend appropriate treatment(s) for the patient. The information is gathered through non-invasive surface electrodes attached to various body surfaces including around the head, under the chin, near the eyes, on the shoulders, and on the lower legs. Small probes are also placed under the nose and on the finger. Belts are also placed around the chest and abdomen to monitor breathing. None of these procedures are painful, and will not interfere with sleep or wake function.

The Multiple Sleep Latency Test (MSLT) is a daytime sleep study consisting of naps throughout the day to assess a patient's daytime sleepiness. The same procedure is used as for the overnight sleep study. An extended EEG is a 12 or 24 hour EEG study with a few additional electrodes applied to measure cardiac activity and breathing.

During some overnight sleep studies, patients may undergo a trial of nasal CPAP to treat obstructive sleep apnea. CPAP is the acronym for continuous positive airway pressure, a device that introduces a stream of pressurized air though a mask over the nose and assists breathing during sleep.

The undersigned hereby authorizes the technologist to photograph and/or videotape, or permit other persons to photograph and/or videotape, the below mentioned person while under the care of The Houston Sleep Center. He/She agrees that the originals and/or prints prepared from such photographs and/or videotapes may only be used for clinical and/or research purposes. If used, such photographs and/or videotapes will not identify by name the below mentioned person. The undersigned hereby authorizes the technologist to perform sleep study(ies), MSLTs, MWTs, or a trial of Nasal CPAP as indicated below, and as requested by the referring physician.

______________________	___/___/___	______________________	____________	___/___/___
Patient Signature	Date	Witness (if under age 18)	Relationship	Date

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
- Shigellosis
- Smallpox
- Syphilis
- Tetanus
- Toxic Shock Syndrome
- Trichinosis
- Tuberculosis

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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.

PAYMENTS 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.

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 we will work you into the schedule. Verbal approvals are not sufficient.

7500 San Felipe, Suite 550 • Houston, Texas 77063
(713) 827-8896 Office • (713) 827-8893 Fax

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

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 $25.00 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 collection agency fees of 30% of my principal balance.
2. And, if the account is referred for litigation, additional attorney's fees of 50% of the principal balance will be assessed.

The collection agency that we use DO report bad debt to the three national credit bureaus. You may also be given notice legally dismissing you for 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 to 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

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

Ronald Zweighaft, MD, FAAN

NOTICE OF SEPARATE BILLING FOR INTERPRETATION FEE(S)
AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN
TODD J. SWICK, MD, PA

I hereby acknowledge that I understand that I will be billed separately for the interpretation of my testing by Todd. J. Swick, MD, PA. This interpretation fee is a separate charge from the technical fee for my sleep studies. I hereby authorize payment directly to Todd J. Swick for the medical benefits for the interpretation of the procedure(s) performed, but not to exceed the reasonable and customary charges for those services. I hereby authorize Todd J. Swick, MD to release any information acquired in the course of my procedure(s) in order to process my insurance claim.

__________________________________ ____________________

Patient Signature Date

____

Parent or Legal Guardian if patient is under the age of 18

If you have any questions concerning billing please call the office of Todd J. Swick, MD, PA directly at 713-465-9282 and ask to speak to the billing department.

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

21216 Northwest Fwy, Suite 510 • Cypress, Texas 77429 (832) 678-2971 Office • (281) 640-8954 Fax

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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 The Institute of Sleep Medicine, d/b/a The Houston Sleep Center as well as 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

7500 San Felipe, Suite 550 • Houston, Texas 77063
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21703 Kingsland Blvd., Suite 101 • Katy, Texas 77450
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THE INSTITUTE OF SLEEP MEDICINE, INC.

DBA: THE HOUSTON SLEEP CENTER

7500 San Felipe, Suite 550
Houston, TX 77063
Phone: (713) 827-8896
Fax: (731) 827-8893

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The Houston Sleep Center

THE INSTITUTE OF SLEEP MEDICINE, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge that I have
(Printed Name of Patient)

have read and reviewed a copy of **THE INSTITUTE OF SLEEP MEDICINE, INC.'s** ***Notice of Privacy Practices.*** This Notice describes how **THE INSTITUTE OF SLEEP MEDICINE, INC.** 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

Sleep Interview Questionnaire

Todd J. Swick, M.D.

Date: ______________

1. Name: Last ________________ First ______________ MI: ___ Male/Female
2. Date of birth: ___/___/____ Age: __________ Marital Status: ______________
3. SSN: ___-___-___ Occupation: ____________ Referring Physician: ____________

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.

Section I: Main Complaint

4. What is your main sleep complaint? ______________________________
5. How long has this been a problem? ______________________________
6. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints? ______________________________
7. Have you had a sleep study or home screen? ___ How long ago? ___ Where? __________
8. Have you ever used nasal CPAP or BiPAP? No___ Yes ___
   If so, how long? ____________ Pressure setting ___________ Mask __________

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Use this 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	Chance of Dozing			
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 no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3
			Total	____

Do you fall asleep or become sleepy when:	Never	Sometimes	Often	Always
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
5. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
6. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3
7. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
8. How would you rate your overall sleepiness?	None	Mild	Moderate	Severe

While asleep do you:	Never	Sometimes	Often	Always
9. Snore?	0	1	2	3
10. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
11. Toss and turn or have restless sleep?	0	1	2	3
12. Suddenly awaken choking or gasping for breath?	0	1	2	3
13. Awaken with heartburn or acid reflux? (acid taste in mouth)	0	1	2	3
14. Walk or talk in your sleep? (circle appropriate event)	0	1	2	3
15. Have nightmares?	0	1	2	3
16. Grind your teeth?	0	1	2	3
17. Have leg or arm jerks, twitches, or kicks?	0	1	2	3
18. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
19. Wake up with a dry mouth?	0	1	2	3
20. Wake up with headaches?	0	1	2	3
21. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
22. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
23. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
24. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
25. Do you dread getting into bed because you think you will "never" fall asleep?	0	1	2	3

Section III: Sleep Habits

26. What time do you go to bed on weekdays? ________________ weekends? ____________
27. How long does it take you to fall asleep? ____________________________________
28. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
29. a.) How often do you awaken at night? ____________________________________
    b.) How long do you stay awake? ____________________________________
    c.) What reason? (bathroom, etc.) ____________________________________
30. What time do you get up on weekdays? ________________ weekends? ____________
31. How many hours of sleep do you get in a typical night? ______________________
32. How do you feel in the morning?
    Very sleepy? _____ Sleepy, but wake up soon _____ Wide awake, ready to go _____
33. When do you function best?

Morning:	Best	Medium	Worst
Afternoon:	Best	Medium	Worst
Evening:	Best	Medium	Worst

Section IV: Medical History

1. Please outline your medical history: Do you have or have ever been told you have

- □ High Blood Pressure
- □ Sinus Problems
- □ Diabetes
- □ Arthritis
- □ Thyroid Problems
- □ Anemia
- □ Heart Disease
- □ Lung Disease
- □ Elevated Cholesterol
- □ Stroke
- □ GI Disease
- □ Cancer
- □ Frequent nighttime urination
- □ Depression and/or Anxiety
- □ Liver Disease
- □ Seizures or Epilepsy
- □ Migraine or Frequent Headaches
- □ Parkinson's
- □ Dementia (Alzheimer's, etc.)
- □ Prior History of Sleep Apnea
- □ Prior History of Restless Legs
- □ Obesity
- □ Abnormal behavior during sleep

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

2. List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name	Dosage	How often	Reason

3. Your weight? ____________ Your height? ____________
4. Do you smoke? __________ If yes, how long? __________ How much? ________/ day
5. Do you drink alcohol? _____ If yes, how long? __________ How much? ____/ day/wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)? _______ How much? ____/ day/wk/mo

General History

1. Have you had any recent problems with your memory or concentration? ________________
   If yes, explain: ____
   ____
2. Have you noticed any changes in your mood or irritability lately? ____________________
   If yes, explain: ____
   ____
3. Are you having any other problems (e.g. stress, anxiety, or pressures)? ________________
   If yes, explain: ____
   ____
4. Have you been depressed lately? ____
   If yes, explain: ____
   ____
5. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)?__
   If yes, explain: ____
   ____
6. Do you often travel across time zones, thereby affecting your sleep/wake schedule? ________
   If yes, explain: ____
   ____
7. Do you work night shifts and/or rotating shifts? ______________________________
   If yes, explain: ____
   ____
8. How did you hear about us? Physician referral/Friend/Web Page/Phone Book
   or advertisement in the ____