



8901 Farm to Market 1960 Bypass Rd W,
Humble, TX 77338
(281) 446-3069 Office
(281) 913-0358 Fax

Dear Humble Dreams Sleep Study Patient,

Thank you for allowing the privilege to provide your sleep study as requested by your physician. Included with this document is a Patient Information form, and a questionnaire, as well as a list of the “do’s and don’ts” pertaining to the sleep study. Also included is a map of our location.

You should plan on arriving for your study at 8:30 pm. Your study will last until 6:00 am the following morning, unless specifically requested otherwise. If you have any questions about the instructions, information or questionnaires, please don’t hesitate to call us during office hours, or if **after office hours** Please call (281) 446-3069.

Here are your follow up instructions to help guide you through the process of events to come, what you can expect and what your responsibilities are as the patient to do:

For your first (diagnostic) sleep lab study:

1. Our Registered Sleep Technologists and Board Certified Sleep Physicians will score and read your study within a few business days.
2. We will then fax the sleep report to your ordering / referring physician.
3. As soon as your report has been faxed to your doctor we will call you to let you know if you need to come back for a second (titration) sleep study with a CPAP/BIPAP machine.
4. At that time we will let you know if you have a copay for the second study, if your insurance has approved the study and schedule you for the second night study (if you have not already been scheduled).

For the second (titration) sleep study:

1. Our Registered Sleep Technologists and Board Certified Sleep Physicians will score and read your study within a few business days.
2. We will fax the second night study to your ordering physician.
3. We will call you as soon as your report has been faxed to your physician.
4. Depending on your doctor that referred you to our facility, you will be instructed to do one of the following:
 - We will call and schedule you an appointment with a Sleep Physician in our facility to go over your report and write a prescription for your equipment. After we have your prescription we will send it out to a DME (durable medical equipment) company who will contact you about setting you up and we will also give you their contact information.

OR

 - We will call and give you the name and information on a Sleep Physician to follow up with and you will have to make an appointment at their office. After the physician sees you in their office, they will send us your prescription and we will send the order out to a DME company. Someone from our office will call you

the same day your prescription is sent out to let you know which company will set you up and can give you their information.

Please be aware, that in some rare cases, patients that have more severe sleep issues MAY need to come in for a third or fourth night study depending on your diagnosis and severity of your sleep issues to find the best therapeutic treatment plan for your diagnosis.

(Your referring physician MAY prescribe you CPAP/BIPAP RX but be aware that ALL patients are required to follow up with a sleep physician within 30-90 days of receiving your CPAP machine so they are able to download your equipment and send to your insurance provider. If you do not follow up with a sleep physician and submit your compliance report to your insurance company, they may take the equipment back and you will not be able to get supplies covered by your insurance in the future when necessary OR in some cases even have to start the entire process all over again from start to finish. This is why we recommend you follow up with a sleep physician after your studies are complete and get your PAP therapy RX from them to avoid these types of issues.

After you have received your CPAP/BIPAP equipment, you should follow up with your sleep physician within 30-90 days. At this appointment you will need to bring your machine with you for your doctor to download the data from your equipment to make sure your pressure is adequate and therapeutic. Also, the insurance company will request a compliance report from your doctor showing you have been using the machine so that you are able to get new supplies (mask, hose and filters every 3 months).

WHAT WILL TAKE PLACE DURING YOUR STUDY:

When you arrive to the lab, with a small tour of the lab you will be escorted to your room. If you have your paperwork the tech will collect it and any copays that may be required. They will give you a little more paperwork to complete for us and you will be asked to change into your sleep attire. The tech will come in to get you set up with the wires (it will take about 30-40 minutes) so you will be ready for bed at your convenience or by 11 pm. When the study is started video monitoring will start up with the computer. This is a safety measure for you the patient and for the technician. Anytime during the study should you need anything, all you have to do is call out for the tech or knock on the table or headboard. There are intercoms in the room so the technician will be able to hear you. At the end of the study before the technician comes to get you up, your study will be ended along with the video recording. Your study will be for a minimum of 6 hours (Insurance Requirement) You will be unhooked from all the wires, and will be given a little more paperwork to complete.

THE DAY OF TESTING:

DO NOTS:

- Please do not take any naps.
- Please do not drink caffeinated beverages after 4:00 p.m.
- Please do not sleep past 9:00 a.m. on the day of your test.

DO'S:

- Eat dinner before reporting.
- Bring a list of all your medications.
- Continue to take all your medications according to your doctor's instructions.
- Bring any medications that you will need to take between the hours of 7:30 p.m. and 7:30 a.m.
- Bring your own sleepwear (No silk clothing). You may bring your own pillow if you wish. *Plan for comfort.*
- If you are on a CPAP or BIPAP machine already, bring your equipment and Interface (Mask, Pillow Circuit, Etc.) for evaluation and pressure checks.

PREPARATION FOR TESTING:

- Please **wash your hair** the night before or the morning of your study and **avoid using hair products** the day of the study. If this is not practical, please wash your hair when you arrive. Please **arrive without make-up**, if possible. If this is not practical, please wash your face to remove make-up when you arrive. Unless you have a beard, please **be clean-shaven**. If you have a beard, we can work around it, but beard stubble is very difficult to work with.
- **Hairpieces and wigs** must be removed. We must be able to get to your scalp to do the test.
- **It is best to not have dark colored or glittery nail polish on your finger nails for your test to get best results.**

GOING HOME:

- You will be awakened at 5:00-5:30 a.m. the next morning and you may leave as soon as you are ready to go. Checkout time is at 7:00-8:00 a.m. at the latest.

GUESTS:

- Adult family members are welcome and encouraged to be present for the educational portion of the study. However, we do discourage anyone from staying over-night unless scheduled for a study. If you require the help of a personal care assistant due to a medical disability, we would be happy to have your PCA stay with you. Please let us know at the time of scheduling so we can accommodate your assistant with a recliner to stay in your room.

IF YOU NEED TO RESCHEDULE OR CANCEL YOUR STUDY:

- If you need to cancel or reschedule your appointment please call us at (832-791-4150). You may leave a message on voicemail if outside of normal business hours. **If you do not show up for your scheduled appointment or cancel within 24 hours of your scheduled appointment, YOU WILL BE CHARGED A \$125.00 NO-SHOW FEE.**

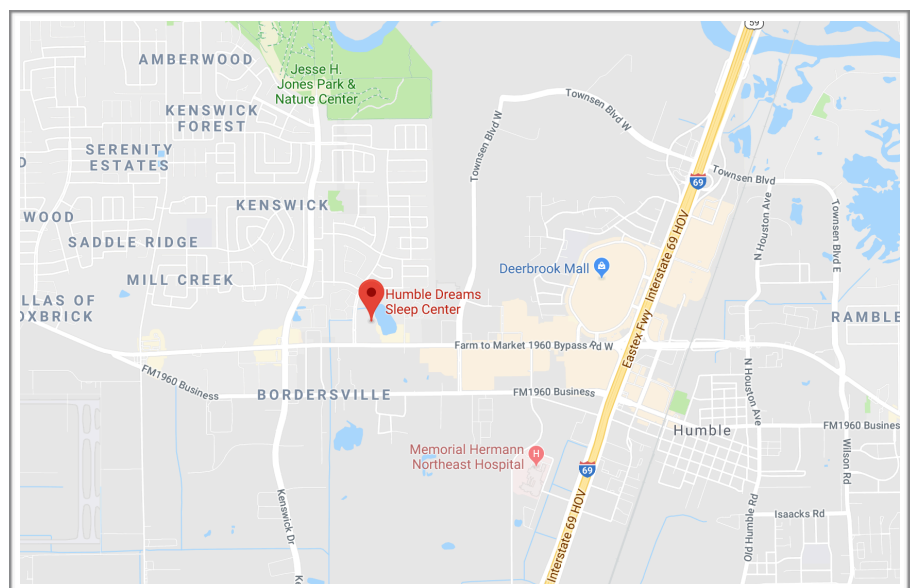
WHEN:

- You will need to report to the sleep lab between 8:00-8:30PM unless told otherwise. **Please do not show up any earlier**, as technicians do not get in to the lab until 7:30 pm. And they will need time to get set up for you.

WHERE:

Please feel free to call (281) 446-3069 during office hours if you have any questions about your sleep study, or where to go

Humble Dreams Sleep Center
8901 Farm to Market 1960 Bypass Rd W,
Humble, TX 77338
(281) 446-3069 - Phone





DIAGNOSTICS AND TREATMENT SLEEP QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Height: _____ ft. _____ in Weight: _____ lbs.

Referring Physician: _____ Neck or collar size: _____ in.

1. If this is someone other than the patient filling out this form, please indicate your relationship to the patient:

2. My sleep is frequently disturbed by: (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Holding Breath | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Choking /Coughing/ Gasping | <input type="checkbox"/> Indigestion or Heartburn | <input type="checkbox"/> Heat/Cold |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Waking Up Feeling Paralyzed | <input type="checkbox"/> Ambient Light/Noise |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Bed Partner/Children/Pets | <input type="checkbox"/> Frequent Need to Urinate |
| <input type="checkbox"/> Creeping/Crawling Feelings in Legs | <input type="checkbox"/> Kicking/Twitching | <input type="checkbox"/> Tossing/Turning |
| <input type="checkbox"/> Teeth Grinding/ Jaw Pain | <input type="checkbox"/> Trouble Falling/Staying Asleep | <input type="checkbox"/> Sleep Walking/Talking |
| <input type="checkbox"/> Nocturnal Enuresis (Bed Wetting) | <input type="checkbox"/> Feeling tired and sleepy during the day | <input type="checkbox"/> Dry Mouth/ Thirst |
| <input type="checkbox"/> Vivid Dreams (Dreaming in Color) | <input type="checkbox"/> Acting Out Dreams | <input type="checkbox"/> Nightmares |

Additional comments: _____

3. Have you ever had a sleep study? Yes No

If so, when and where? _____

4. Are you currently on CPAP therapy? Yes No

If so:

- What pressure are you presently using? _____ cm
- Does the mask fit OK? Yes No
- Do you use it every night? Yes No

5. Have you recently lost or gained weight? Yes No

If so, how much? Lost Gained _____ lbs.

6. Do you smoke? Yes No

If so, how much and for how long? _____ Cigarettes _____ Day _____ Years

7. Do you consume alcoholic beverages? Yes No If so, how much? _____

8. Do you consume caffeinated beverages? Yes No If so, how much? _____

9. Please check all major medical problems:

- | | | | | |
|--|--|---------------------------------------|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting/Black Outs |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TMJ | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Reflux/GERD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |

- Arthritis
 Thyroid Condition
 COPD
 Bronchitis
 Fibromyalgia

Please list any illness not listed above:

10. Please list **ALL** medications you take including over the counter: *(Circle any medications you take before bed)*

11. Are you allergic to any drugs? **Yes** **No** If yes, please list:

12. Have you had nasal or sinus surgery? **Yes** **No** If yes, please describe:

YOUR SLEEP PATTERNS:

1. What time do you usually go to bed? Weekdays: ____:____ Weekends: ____:____

2. What time do you usually wake up? Weekdays: ____:____ Weekends: ____:____

3. Do you take naps during the day? **Yes** **No**
 If yes, when, how many, and for how long?

4. Do you suffer from pain that interferes with your sleep? **Yes** **No**
 If so, please explain:

5. Have you been told that your snoring is (circle the appropriate response):

Light **Moderate** **Loud** **Very Loud**

6. Does it disturb your bed partner? **Yes** **No**

7. Has anyone told you that you stop breathing in your sleep? **Yes** **No**

8. Do you feel refreshed when you wake up in the morning? **Yes** **No**

9. Do you grind your teeth together while sleeping? **Yes** **No**

10. Have you ever walked in your sleep? **Yes** **No**

If so, at what age: _____

11. Do you have frequent nightmares? **Yes** **No**

12. Have you injured yourself or a bed partner “acting out” dreams? **Yes** **No**
 If so, please explain: _____
13. Do you experience vivid dreams upon falling asleep or waking up? **Yes** **No**
14. Have you had spells where you feel that you are unable to speak or move when you are about to fall asleep or when you are awakening? **Yes** **No**
15. Have you ever had a seizure or suspect you may have had a seizure? **Yes** **No**
 If so, please explain: _____

DURING THE DAY:

1. Have you experienced sudden muscle weakness (*that makes you fall or causes your knees to buckle*)?
 When laughing? **Yes** **No**
 When angry? **Yes** **No**
 Other: _____
2. Do you feel tired during the day? **Yes** **No**
3. Are you sleepy or groggy during the day? **Yes** **No**
4. Does sleepiness interfere with your work? **Yes** **No**
5. Have you experienced sudden or uncontrollable sleep attacks? **Yes** **No**
6. Do you get sleepy while driving? **Yes** **No**

Epworth Sleepiness Scale

Instructions: Please give the answer that most accurately describes the chances of you dozing off or falling asleep in the following situations. This refers to your usual way of life in recent times.

0 - Never; 1 - Slight; 2 - Moderate; 3 - High

Sitting and Reading	
Watching Television	
Sitting Inactive in a Seminar, Theater, or Meeting	
As a Passenger in a Car for One Hour	
Lying Down to Rest in the Afternoon	
While Having a Relaxed Conversation	
Sitting Quietly After Lunch	
In a Car While Stopping at a Traffic Signal	
Total Points (Max/24)	

Please note, for liability purposes, if you have questions regarding your sleep study results, our staff cannot give you a diagnosis or give you your results. However, if you have seen your physician to get your results and feel like you have more questions or do not understand the reports you were given, feel free to contact us at (281) 446-3069 and ask for Rob (our lab and sleep tech manager). He is in the sleep lab Monday through Friday and he can try to help explain any questions you may have in further detail for you. He will only be able to do this if we can confirm you have followed up with your physician first to get your diagnosis. You can do this by asking your physician’s office to fax us your follow up progress note as confirmation you have been seen. Our fax number is (281) 913-0358.

X

Signature

Date



Authorization for Treatment

Name: _____ Date: _____
(Print patient full name)

Authorization for Treatment

I hereby voluntarily consent to medical care for diagnostic procedures and medical treatment as ordered by my physician, his/her assistants or designees, as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Signature of patient/guardian _____ Date: _____

Assignment of Benefits

I hereby authorize *Humble Dreams Sleep Center* all my rights, title and interest in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that Humble Dreams Diagnostics Center maybe out of network with some insurance companies and am responsible for any remaining balances. I understand that I am responsible for all the charges not covered by the assignment and hereby promise to pay the remaining balance.

Signature of patient/guardian _____ Date: _____

Authorization for Release of Information

I authorize *Humble Dreams Sleep Center* to request or release to or from the insurance carrier, Social Security Administration, third party administrators, referring physicians, or any other party that may be liable for all or part of medical charges information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during the period of care.

Signature of patient/guardian _____ Date: _____

Authorization for the Video Monitoring and Photograph

I authorize *Humble Dreams Sleep Center* to monitor my sleep session via video camera and video monitor and to record the sleep session on videotape for the purpose of diagnostic observation of the polysomnographic study that has been ordered by my physician. I understand that any videotape will be destroyed after my polysomnographic study has been interpreted and the clinical report has been generated. In addition, I authorize *Humble Dreams Sleep Center* to take still photographs of me for the purpose of display on the clinical report of the result of my polysomnographic study. The still photographs will be stored digitally for a maximum of 1 year and then destroyed.

Signature of patient/guardian _____ Date: _____



Medical Records Release Authorization

I, _____ hereby authorize:

Humble Dreams Diagnostics Center
8901 Farm to Market 1960 Bypass Rd W,
Humble, TX 77338
P: (281) 446-3069 F: (281) 913-0358

(Please check off the following items)

- Sleep Study Reports
- Any progress notes from physicians
- Patient questionnaire forms
- Demographics/ insurance information
- Prescriptions for DME (durable Medical Equipment)
- Any billing information or receipts

To give the following items (as checked above) to the following people:

_____	_____
Person name	relationship
_____	_____
Person name	relationship
_____	_____
Person name	relationship
_____	_____
Person name	relationship
X _____	_____
Signature	Date

I fully understand that if medical records are requested by mail, email or fax that Humble Dreams Diagnostics Center is not responsible for your personal and/or medical information when disclosed to a third party and the information may no longer be protected by the federal or state laws and may be redisclosed by the person or entity that receives this information.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Home Phone: _____ Cell Phone _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: _____ Date of Birth: _____

PRIMARY INSURANCE

Name of Insured: _____ Relation to Patient: _____

Insurance Name: _____ Insurance Phone: _____

Member ID Number: _____ Group Number: _____

SECONDARY INSURANCE

Name of Insured: _____ Relation to Patient: _____

Insurance Name: _____ Insurance Phone: _____

Member ID Number: _____ Group Number: _____

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- ❖ I hereby authorize payment of medical benefits billed to my insurance to Humble Dreams Diagnostics Center (HDDC) unless otherwise informed.
 - ❖ I hereby accept responsibility to pay for any service(s) provided to me that are not covered by my insurance.
 - ❖ I agree to pay all co-payments, coinsurance and deductibles at the time service is rendered.

Signature of Patient or Guardian

Date