Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

ACCREDITED MEMBER CENTER

3259 N. Windsong Dr.
Prescott Valley, Arizona
86314
928-772-6422
Fax 928-772-6425
PVsleep.com

NEW PEDIATRIC PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Name: Last _____ First _____ Middle Initial _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____

Pharmacy Name and Phone: _____

Referring Health Care Provider: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ ID #: _____ Group #: _____

Relationship to Patient: _____

Secondary Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ ID #: _____ Group #: _____

Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION

Guarantor's Name: Last _____ First _____ Middle Initial _____

Social Security #: _____ Date of Birth: _____ Age: ____ Gender: ____ Marital Status: (S,M,W,D) _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Employer: _____

I, the undersigned, certify that my dependent or I have insurance coverage as indicated above. I assign directly to Sleep Disorders Center of Prescott Valley, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Patient/Parent or Legal Guardian Signature **Relationship** **Date**

Please print and bring to your appointment or email.
mailto:info@pvsleep.com

SLEEP EVALUATION QUESTIONNAIRE

Please answer each of the following questions:

Child's name: _____

Child's racial/ethnic background:

White/Caucasian _____ Black/African American _____ Asian _____
Native American _____ Latino/Hispanic _____ Multiracial _____

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

FAMILY INFORMATION

MOTHER
Age:____ Marital Status: Married____ Single____ Separated____ Divorced____ Widowed____ Remarried____
Education:
Work: Full-time____ Part time____ Unemployed____
Occupation:
FATHER
Age:____ Marital Status: Married____ Single____ Separated____ Divorced____ Widowed____ Remarried____
Education:
Work: Full-time____ Part time____ Unemployed____
Occupation:

FAMILY SLEEP HISTORY

Does mother, father, or sibling have any of the following sleep disorders?	Mother	Father	Sibling
Insomnia			
Snoring			
Sleep Apnea			
Restless Legs Syndrome			
Periodic Limb Movement Disorder			
Sleep walking/Sleep terrors			
Sleep Talking			

HEALTH HABITS

Does child drink caffeinated beverages? No____ Yes____ Amount per day_____
Wet the bed? No____ Yes____ How often?_____

CURRENT MEDICAL HISTORY

Please list any medication your child currently takes:		
MEDICINE	**DOSE**	**HOW OFTEN?**
1.		
2.		
3.		
4.		
5.		
6.		

LONG-TERM MEDICAL PROBLEMS

If your child has long-term medical problems, please list the three you think are most important.
1.
2.
3.

SURGERIES / HOSPITALIZATIONS

Has your child had their tonsils removed? Yes _____ Age _____
Has child had their adenoids removed? Yes _____ Age _____
Has child had ear tubes? Yes _____ Age _____

PREGNANCY / DELIVERY

Pregnancy	Normal____	Difficult_____	
Delivery	Term____	Pre-term____	Post-term____
Child's birth weight:			
Only child?	Yes____	No____	If no, circle birth order 1st 2nd 3rd 4th 5th 6th

SCHOOL PERFORMANCE

Child's grade in school:
Has your child ever repeated a grade? Yes____ No____
Is your child enrolled in any special education class? Yes____ No____
How many school days has child missed so far this year?
How many school days did child miss last year?
How many school days was child late for school this year?
How many school days was child late last year?
Child's grades this year: Excellent_____ Good_____ Average_____ Poor_____ Failing_____

DOES YOUR CHILD
Watch TV in bed? Yes_____ No_____
Read in bed? Yes_____ No_____
Eat in bed: Yes_____ No_____
Use a phone, tablet, or computer in bed? Yes_____ No_____
Worry in bed? Yes_____ No_____

SLEEP HISTORY

WEEKDAY SLEEP SCHEDULE

How much time does child sleep in 24 hours on **weekdays**? (combine day and night) _____hours _____minutes

Child's usual **bedtime** during **weekdays**: ____:____

Child's usual **wake** time in **morning**: ____:____

WEEKEND / VACATION SLEEP SCHEDULE

Amount of time child sleeps in 24 hours on **weekends and vacations**? (combine day and night)
_____hours _____minutes

Child's usual **bedtime** on **weekend/vacation nights**: ____:____

Child's usual **wake time** on **weekend/vacation mornings**: ____:____

NAP SCHEDULE

Number of **days each week** child takes a nap: (circle) 0 1 2 3 4 5 6 7

If child naps, time of usual nap: Nap 1____:____a.m. p.m. to ____:____a.m. p.m. (circle)
Nap 1____:____a.m. p.m. to ____:____a.m. p.m. (circle)

GENERAL SLEEP

Does child have a regular bedtime routine? ___yes ___no

Does child have own bedroom? ___yes ___no

Does child have own bed? ___yes ___no

Is a parent present when child falls asleep? ___yes ___no

Child usually **falls asleep** in	Child **sleeps most of the night** in	Child usually **wakes in the morning** in
___own room in own bed (alone)	___own room in own bed (alone)	___own room in own bed (alone)
___parent's room in own bed	___parent's room in own bed	___parent's room in own bed
___parent's room in parent's bed	___parent's room in parent's bed	___parent's room in parent's bed
___sibling's room in own bed	___sibling's room in own bed	___sibling's room in own bed
___sibling's room in sibling's bed	___sibling's room in sibling's bed	___sibling's room in sibling's bed

Child is usually put to bed by: ___Mother ___Father ___Both parents ___Self ___Other_____

Amount of time child spends in **own** bedroom before going to sleep: _____minutes

Does child often awaken during the night? _____yes _____no
If yes, what is the typical number of times your child awakens? _____

After nighttime awakening, does child has difficulty falling back to sleep? ___yes ___no
If yes, do you think this is a problem? ___yes ___no

Is child difficult to awaken in the morning? ___yes ___no
If yes, do you think this is a problem? ___yes ___no

Child is a poor sleeper? ___yes ___no
If yes, do you think this is a problem? ___yes ___no

Is child excessively sleepy? ___yes ___no

Does child fall asleep in school? ___yes ___no

Does child nap after school? ___yes ___no

Circle best answer

CURRENT SLEEP SYMPTOMS

Does your child snore? Never Occasionally Frequently Always
Does position affect snoring? Yes No If yes, what position is worse? Back Stomach Right side Left side
Does your child wake up coughing? Daily Weekly 1-3 times per month Never
Does your child wake up choking? Daily Weekly 1-3 times per month Never
Does your child stop breathing during sleep? Daily Weekly 1-3 times per month Never
Does your child wake with a stomach acid taste in their mouth? Daily Weekly 1-3 times per month Never
Does your child wake up with dry mouth/sore throat/headache? Daily Weekly 1-3 per month Never
Does your child wake up confused in the morning? Daily Weekly 1-3 per month Never
Has your child experienced excessive weight gain over the past months or years? Yes No
Have you attempted to place your child on a diet to lose weight? If yes, how much weight? _____
Does your child dream during naps or sleep? Yes No
Has your child ever felt sudden muscle weakness when laughing, angry, or surprised? Yes No If yes, describe_____
Has your child ever been unable to move their body when falling asleep or waking? Yes No If yes, describe_____
Has your child ever reported any visual hallucinations or exceptionally vivid dreams just as falling asleep or awakening? Yes No If yes, describe_____

PARASOMNIAS

Does your child have episodes of flailing arms/kicking legs/talking/screaming during sleep?

Nightly Weekly 1-3 times per month Never

Are they able to recall a dream preceding these episodes? Nightly Weekly 1-3 times per month Never

Are they able to remember an episode in the morning? Yes No

If yes, describe_____

Does your child walk in their sleep? Yes No If yes, how often?_____

In a typical week, mark the frequency of each of these:

	ALWAYS	OFTEN	SOMETIMES	SELDOM	NEVER	DON'T KNOW
Restless Leg						
Sweating when sleeping						
Poor appetite						
Nightmares						
Kicks legs in sleep						
Gets out of bed at night						
Trouble staying in bed						
Resists going to bed at night						
Grinds teeth						
Uncomfortable, creepy crawly feeling in legs						

MEDICAL AND PSYCHIATRIC HISTORY

	YES	AGE OF DIAGNOSIS
Frequent nasal congestion		
Trouble Breathing through nose		
Sinus problems		
Chronic bronchitis or cough		
Allergies		
Asthma		
Frequent colds or flu		
Frequent ear infections		
Frequent strep throat infection		
Difficulty swallowing		
Acid reflux (gastroesophageal reflux)		
Poor or delayed growth		
Excessive weight		
Hearing problems		
Speech problems		
Vision problems		
Seizures/Epilepsy		
Morning headaches		
Cerebral palsy		
Heart disease		
High blood pressure		
Sickle cell disease		
Genetic disease		
Chromosome problem (e.g. Down's)		
Autism		
Developmental delay		
Hyperactivity/ADHD		
Obsessive Compulsive Disorder		
Depression		
Suicide attempt		
Learning disability		
Drug use/abuse		
Behavioral disorder		
Psychiatric admission		

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize _____ _____ _____
Physician/Healthcare Facility Phone number Fax number

_____
Address

To release information on _____ (Patient's Name) _____ (Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records including those from my other healthcare providers that the above named healthcare provider my hold, by means of mail, fax, or other electronic methods.

___ The most recent two years of pertinent information (chart notes, labs, x-rays, EKGs)
___ Sleep studies with recent medical notes.
___ Specific information (please specify): _____

To: **Sleep Disorders Center of Prescott Valley, LLC**
3259 N. Windsong Dr.
Prescott Valley, AZ 86314
(928) 772-6422
Fax (928) 772-6425

The medical information/records will be used for the following purpose:

___ Continued care with other healthcare provider
___ Transfer to another healthcare provider
___ Other (specify) _____

DURATION

This authorization shall be effective immediately and remain in effect until _____ (Date)

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of the authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____ _____
Signature of Patient *or representative* Date Relationship *if other than patient*

_____ _____
Patient's Name (print) Patient's date of birth

_____ _____
Witness Name Witness Signature

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices, ("Notice") apply to Sleep Disorders Center of Prescott Valley, LLC, its affiliates, and its employees. Sleep Disorders Center of Prescott Valley, LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Sleep Disorders Center of Prescott Valley, LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. With such request, you must provide an appropriate alternative

address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to the Privacy Officer at the address below.

Research: In limited circumstances, we may use and disclose your protected health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board, which oversees the research, or by representations of the researchers that limit their use and disclosure of your information.

Fundraising: We may use your information to contact you for fundraising purposes. We may disclose this contact information to a related foundation so that the foundation may contact you for similar purposes. If you do not want us or the foundation to contact you for fundraising efforts; you must send such request in writing to the Privacy Officer at the address below.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:
• Any purpose required by law;
• Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
• To your employer when we have provided health care to you at the request of your employer;
• To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
• Court or administrative ordered subpoena or discovery request;
• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
• To coroners and/or funeral directors consistent with law;
• If necessary to arrange an organ or tissue donation from you or a transplant for you;
• If you are a member of the military, we may also release your protected health information for national security or intelligence activities; and
• To workers' compensation agencies for workers' compensation benefit determination.

DISCLOSURES REQUIRING AUTHORIZATION:

Psychotherapy Notes: We must obtain your specific written authorization prior to disclosing any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of a person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment, or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your protected health information for marketing, except if the communication is in the form of (1) a face-to-face communication with you, or (2) a promotional gift of nominal value.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:
• Public health activities;
• Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
• Treatment and payment purposes;
• Health care operations involving the sale, transfer, merger or consolidation of all or part of our business and for related due diligence;
• Payment we provide to a business associate for activities involving the exchange of protected health information that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the
performance of such activities;
• Providing you with a copy of your health information or an accounting of disclosures;
• Disclosures required by law;
• Disclosures of your health information for any other purpose permitted by and in accordance

with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
• Any other exceptions allowed by the Department of Health and Human Services.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable electronic format, if readily producible. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Amendments to Your Protected Health Information: You have the right to request in writing that protected health information that we maintain about you be amended or corrected. We are not obligated to make requested amendments, but we will give each request careful consideration. All amendment requests, must be in writing, signed by you or legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Protected Health Information: You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Protected Health Information: You have the right to request restrictions on uses and disclosures of your protected health information for treatment, payment, or health care operations. We are not required to agree to most restriction requests, but will attempt to accommodate reasonable requests when appropriate. You do, however, have the right to restrict disclosure of your protected health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which you, or someone other than the health plan on your behalf, has paid Sleep Disorders Center of Prescott Valley, LLC in full. If we agree to any discretionary restrictions, we reserve the right to remove such restrictions as we appropriate. We will notify you if we remove a restriction imposed in accordance with this paragraph. You also have the right to withdraw, in writing or orally, any restriction by communicating your desire to do so to the individual responsible for medical records.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice. To do so, please submit a request to the Privacy Officer at the address below.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at the below address. There will be no retaliation for filing a complaint.

U.S. Department of Health and Human Services
Office for Civil Rights
800-368-1019
TDD: 1-800-537-7697

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Sleep Disorders Center of Prescott Valley, LLC Privacy Officer by phone at 928-772-6433 or at the following address: 3259 N. Windsong Dr., Prescott Valley, AZ 86314.

This Notice of Privacy Practices is also available on our Sleep Disorders Center of Prescott Valley, LLC web page at www.pvsleep.com.

Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

I acknowledge that I have read the Sleep Disorders Center of Prescott Valley, LLC Notice of Privacy Practices.

The Sleep Disorders Center of Prescott Valley, LLC may release health information to:

____ Spouse: _____
Name

____ Caregiver: _____
Name

____ Other: _____
Name

_____
Patient Name

_____
Signature Date

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OF PRESCOTT VALLEY, LLC

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FINANCIAL POLICY

All patients must sign the Financial Policy form. Please read and sign.

Insurance:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All co-pays and deductibles will need to be collected the day of your appointment/sleep study. If your insurances company needs a referral, it will be up to your primary doctor to obtain and fax this to our office before the time of service. As a courtesy, your insurance company will be billed for you/ however, you will be responsible for all non-covered charges and any payment mailed directly to you by your health insurance company. Questions or concerns regarding changes must be directed to the Sleep Disorders Center of Prescott Valley, LLC.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary.

Bad Debt/Collections:

If an account is turned over to a collection agency, all visits will be charged on a cash basis, NO EXCEPTIONS. If my account is placed for collection, I acknowledge responsibility for associated collection expenses (a 25% collection fee will be added to my balance turned over to the collection agency). Once your account has been turned over to collections, you will no longer be seen at our office until the debt is satisfied. There will be a $25 charge for all returned checks.

To My Insurance Carriers(s):

1) I authorize the release of medical information necessary to process insurance claim(s).

2) I authorize and request payment of medical benefits directly to my physicians.

3) I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.

4) I agree that a photocopy of this form may be used in lieu of the original.

If you have any questions about the above information or any uncertainty regarding insurance, please do not hesitate to ask us. We are here to help you.

Authorization to pay; I hereby authorize payment directly to the Sleep Disorders Center of Prescott Valley, LLC, for medical benefits, if any, and otherwise payable to me for services. I understand I am financially responsible for the charges not covered by my insurance. I authorize the use of this signature on all insurance claims.

Patient's Name (Printed)	Signature of Patient or Responsible Party	Date

Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

We must have these items 48 hours prior to your scheduled appointment:

CHECKLIST

____ **New patient paperwork completely filled out**

____ **Copy of insurance card(s)**

____ **Driver's License / Photo ID**

____ **Prior sleep studies and other records, if applicable**

____ **Current medication list**

____ **Smartcard if you are currently on a machine**

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Medical Director

Telemedicine Patient Consent Form

I, _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider inappropriate or am unwilling to have heard by other persons I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility. I understand that some or all of my medical information may be used for teaching or educational purposes.

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Signature of patient (or parent/guardian): _____ Date: _____

Email: _____ Phone: _____

Signature of witness: _____ Date: _____

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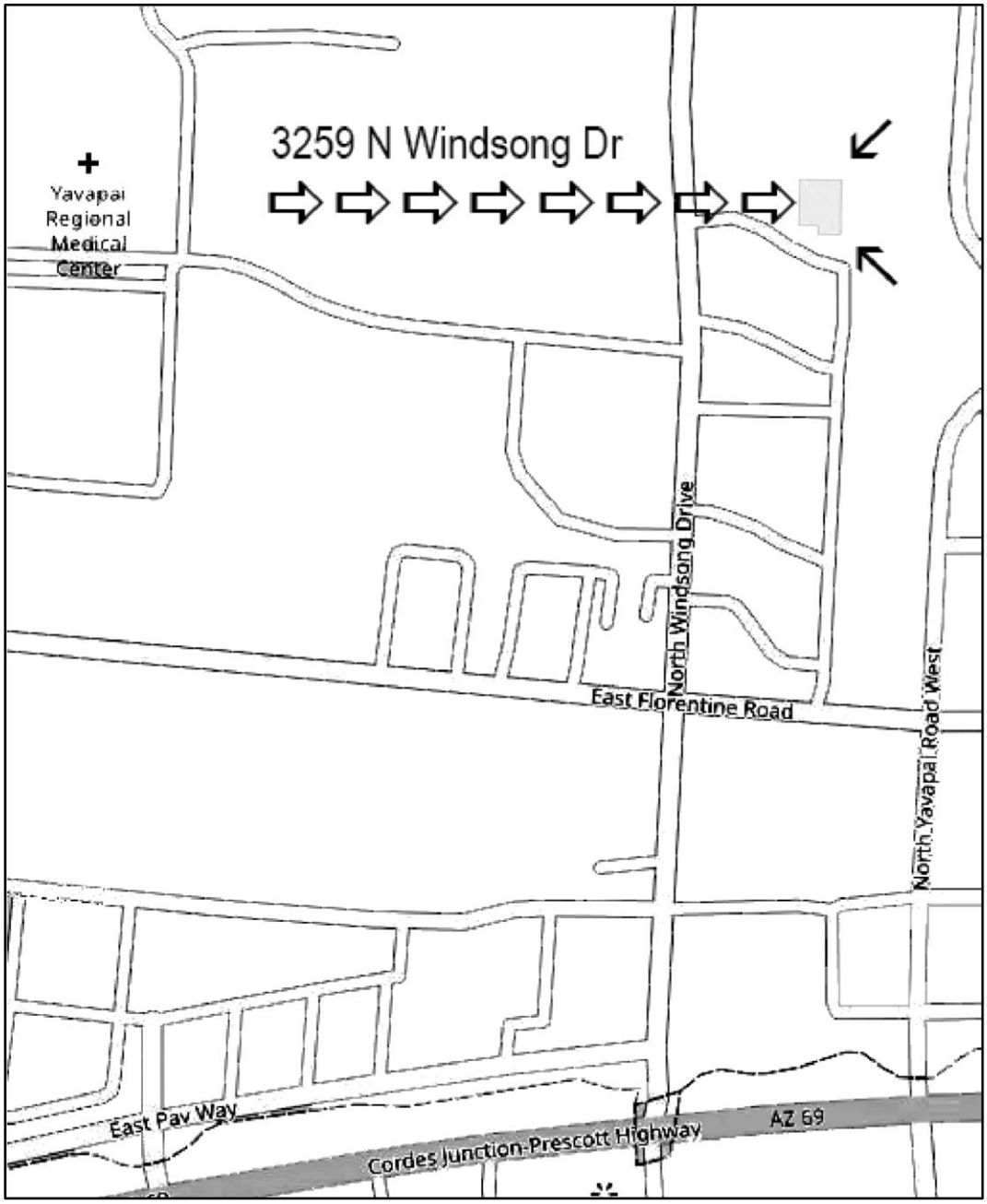
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

OFFICE LOCATION

3259 N Windsong Dr, Prescott Valley



AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
ACCREDITED MEMBER CENTER

Testing and evaluation of sleep-related disorders
3259 N. Windsong Dr. ♦ Prescott Valley, Arizona 86314 ♦ 928-772-6422 ♦Fax 928-772-6425