Registered Polysomnographic Technologist on Staff

Sleep Studies, Consultations, Homestudies and CPAP Clinics

Respiratory Therapist on Staff

Dr. Sever Surdulescu, Medical Director (Lake Norman Pulmonary & Critical Care Spec.)
Board Certified in Sleep Medicine
www.piedmontsleepcenter.com

H
1070 Lenoir Rhyne Blvd. SE
Hickory, NC 28602
(Lower Level of Eye Care Center)
Phone: (828) 322-3111
Fax: (828) 322-3160

L
302 Mulberry St. SW
Lenoir, NC 28645
(across from Caldwell Memorial)
Phone: (828) 322-3111
Fax: (828) 322-3160

NAME________________________
APPT. DATE___________________
ARRIVAL______________________
WAKE-UP______________________

INSTRUCTIONS FOR ALL-NIGHT SLEEP STUDIES:

1. PLEASE RING **DOOR BELL** WHEN YOU ARRIVE.
2. PLEASE HAVE **CLEAN HAIR, NO LOTION, NO MAKEUP.**
3. PLEASE BRING A **LIST** OF PRESCRIBED MEDS THAT YOU ARE TAKING. TAKE ALL OF YOUR PRESCRIBED MEDS AS NORMAL. DO NOT TAKE ANY “OVER THE COUNTER” DRUGS, ESPECIALLY ALLERGY OR COLD REMEDIES. YOU MAY TAKE TYLENOL OR ADVIL.
4. PLEASE BRING AN **UPDATED INSURANCE CARD.**
5. IF YOU HAVE A COPAY, PLEASE BRING CASH OR CHECK. (PLEASE MAKE CHECKS PAYABLE TO: LAKE NORMAN SLEEP CENTER).
6. **NO ALCOHOL OR CAFFEINE.**
7. **DO NOT NAP.**
8. **WEAR PAJAMAS, OR SHORTS AND A T-SHIRT.** YOU MAY BRING YOUR OWN PILLOW.
9. FRIENDS OR FAMILY MAY **NOT** REMAIN IN LAB DURING STUDY.
10. PLEASE LET US KNOW BEFOREHAND IF YOU NEED SPECIAL ASSISTANCE.
11. DO NOT BRING A TV OR RADIO. CELL PHONES NEED TO BE TURNED **OFF** UPON ARRIVAL.
12. IF YOU USE A **CPAP** MACHINE AT HOME, PLEASE BRING YOUR **MASK.**
13. IF YOU ARE ON **OXYGEN,** PLEASE LET US KNOW AND BRING A **CANNULA.**
14. BRING THIS INFORMATION PACKET WITH YOU ON THE NIGHT OF STUDY.

PLEASE UNDERSTAND THAT WE CAN NOT GIVE YOU ANY INFORMATION REGARDING YOUR SLEEP STUDY RESULTS.

If you are unable to keep your appointment, please let our office know within 48 HOURS so we can reschedule you. We only have 2 patients per night, and count on each one to show up to their scheduled appointment. If you are a no-show, you will not be rescheduled.

***Insurance Benefits are estimates only and not a guarantee of payment.**

You are responsible for providing the correct insurance information. Please let us know if the information is correct and if you change policies.

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DIRECTIONS TO OUR HICKORY CENTER:

From Statesville, I-40 west towards Hickory, take Exit 125. Take right. Go to stoplight where Biscuitville is located (11th Ave Blvd SE) and take a left. Then, it will be first road on right. Follow until you see our signs (Lower level of Eye Care Center.)

From Lenoir or Morganton, take US-321S. Take exit I-40 East/Statesville then take Exit 125. Turn left on Lenoir Rhyne Blvd. Go to stoplight where Biscuitville is located (11th Ave Blvd SE) and take a left. Then, it will be first road on right. Follow until you see our signs (Lower level of Eye Care Center.)

From Hickory, turn at stoplight at Biscuitville on L-R Blvd. Take first road on right. Follow until you see our signs (Lower level of Eye Care Center.)

DIRECTIONS TO OUR LENOIR CENTER:

From Taylorsville, once you come into Lenoir, turn left onto NC-18. Travel 0.7 miles and turn right onto Mulberry St SW. Travel 0.4 miles and you will find us across from Caldwell Memorial Hospital.

From Boone, take 321 South towards Lenoir for 17.3 miles. Turn right onto 321 Alt/N Main St. and travel 0.9 miles. Turn slightly left onto 321 Alt S/N Main St. and travel 1 mile. Turn left on College Ave SW and then turn right onto Mulberry St SW. Travel 0.2 miles and you will find us across from Caldwell Memorial Hospital.

From Jefferson, take Valley Blvd until it turns into 321 South. Travel for 17.3 miles. Turn right onto 321 Alt/N Main St. and travel 0.9 miles. Turn slightly left onto 321 Alt S/N Main St. and travel 1 mile. Turn left on College Ave SW and then turn right onto Mulberry St SW. Travel 0.2 miles and you will find us across from Caldwell Memorial Hospital.

From Wilkesboro, start out going west on W Park Dr toward US-421 BR. Turn left onto US-421 BR W and travel for 1.2 miles. Turn left onto US-421 S/NC-16 S/WATSON BRAME EXPY and travel for 1.5 miles. Merge onto NC-16 S/NC-18 S via EXIT 286A toward Taylorsville/Lenoir and travel 3.2 miles. Turn right onto NC-18 and travel 24.4 miles. Turn left onto Morganton Blvd SW/US-64/NC-18 BYP and travel 0.7 miles. Turn right onto Mulberry St SW and travel 0.2 miles. You will find us across from Caldwell Memorial Hospital. Building located beside Wig Bank.

For Patients Only

(Hickory) Direct Number (828) 322-3111
(Lenoir) Direct Number (828) 754-9621 (Night of sleepstudy only)

Doctor: ______________________________

PATIENT INFORMATION

Name: ____
Address: ____
____
City, State: ____
Phone: ___________________ [ ]Home [ ]Work [ ]Other
Phone: ___________________ [ ]Home [ ]Work [ ]Other

Patient ID #: ___________________ Sex: [ ]M [ ]F
Date of Birth: __________________________________
Social Security #: __________________________________
Marital Status: [ ] Married [ ] Single [ ] Divorced
Referring Physician:
Primary Physician: __________________________________

Patient Employment

[ ] Same as Patient

Phone: ____
Employer: ____
Address: ____

Workers Compensation?

Injury: Yes___ No___ Work Related? Yes___ No___
Description of accident/injury: Date of Injury:
____
____

RESPONSIBLE PARTY

[ ] Same as Patient

Name: ____
Address: ____
____
City, State: ____

EMPLOYMENT

Employer: __________________________________
Phone: __________________________________
Phone: __________________________________
Social Security #: __________________________________
Date of Birth: ____

PRIMARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: __________________________________
Insured Phone: __________________________________
Insurance Company: __________________________________
Date of Birth: __________________________________

Relationship to Patient: _____________________________
Social Security #: _____________________________
Insured ID: _____________________________
Policy Group: _____________________________

SECONDARY INSURANCE

[ ] Same as Patient [ ] Same as Guarantor [ ] Other

Insured Party: __________________________________
Insured Phone: __________________________________
Insurance Company: __________________________________
Date of Birth: __________________________________

Relationship to Patient: _____________________________
Social Security #: _____________________________
Insured ID: _____________________________
Policy Group: _____________________________

I hereby authorize Lake Norman Pulmonary/Piedmont Sleep Center to release any information acquired in the course of my examination to the insurance company. I understand that Lake Norman Pulmonary/Piedmont Sleep Center will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care. Should my insurance deny for such reasons as: an authorization, deductible, or non-covered service, I understand that I will be responsible for my bill. This authorization shall remain valid until revoked in writing.

____

Patient's Signature Date

Name of Patient ___________________________________ Date of Birth ____________________________

____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other __________________________________
☐ Spouse	☐ Financial ☐ Medical as follows: ______________________ ____
☐ Parent (provide name) ____	☐ Financial ☐ Medical as follows: ______________________ ____
☐ Other (provide name) ____	☐ Financial ☐ Medical as follows: ______________________ ____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

____

Please review the financial policies for our office. If you have any questions about any of these policies, please ask one of our staff members.

1. If your health insurance coverage requires a copayment by you for office visits, you will be required to pay that copayment before being seen by our health care provider. Your appointment may be rescheduled if no copayment is made.
2. If your health insurance coverage is subject to a deductible and if it has not yet been met, you may be required to pay on that prior to being seen by our health care provider.
3. If a study or procedure is scheduled by one of our providers, our staff ***may*** contact your insurance carrier to obtain any prior authorizations, if required.
4. Because all insurance policies are different, our staff members do not know what your coverage is for certain procedures or tests. Therefore, we cannot tell you what your financial responsibility will be for any ordered services. If you have a question about what your coverage is for certain procedures, you will need to contact your insurance company directly to obtain that information.
5. You are required to bring your insurance card for every office visit. If no insurance card is provided, charges will be billed to the patient directly.
6. If you carry a balance on your account, you will be asked to pay on your account prior to being seen if no other prior payment arrangements have been made.
7. Insurance benefits are estimates only and not a guarantee of payment.

I, ________________________________, have read the above policies and understand the content.

____ ______________________

Patient Date

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Lake Norman Pulmonary & Critical Care Specialists, PA. / Piedmont Sleep Center, Inc.

____ ___________________________________

Patient Name (Please Print) Social Security Number

____ ______________________

Signature of Patient (or patient's representative) Date

Date: ____________________________

Name: ____ Date of Birth: __________________________

Who referred you to us? ____

Who is your primary care physician? ____

What is the reason for your visit? ____

Please tell us about your medical history.

Do <u>you</u> have a history of:			*If yes, please explain*
Lung problems	Yes	No	
Heart problems	Yes	No	
Diabetes	Yes	No	
Cancer	Yes	No	
High blood pressure	Yes	No	
Stroke	Yes	No	
Stomach/digestion problems	Yes	No	
Other	Yes	No	

Please tell us about <u>your family</u> medical history.

Mother	
Father	
Grandparents	
Brothers/Sisters	
Children	

Please tell us about any <u>surgeries you have had</u>.

Social History:

What is your marital status? ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Are you currently employed? ( ) Yes ( ) No ( ) Retired

Where do you work? / Where did you work? ____

____

Have you ever been exposed to any hazardous materials? ( ) Yes ( ) No ( ) Unsure ______________________

____

Have you traveled recently outside the US? ( ) Yes ( ) No *If 'yes', please tell us where:*

____

Do you have pets at home? ( ) Yes ( ) No *If 'yes', please tell us about them:* ______________________

____

What are your hobbies? ____

Smoking:

Are you currently smoking? ( ) Yes ( ) No ( ) Ex-smoker *If 'yes', please tell us how long you have been smoking and how much you smoke. If you are an ex-smoker, please tell us how long you smoked and how much you smoked:*

____

Alcohol:

How many alcoholic beverages do you drink on average? ____

Caffeine:

How many caffeinated beverages to you drink on average? ______________________________________

Sleep:

Do you snore? ( ) Yes ( ) No ( ) Unsure

Do you feel like you get adequate sleep at night? ( ) Yes ( ) No How much sleep per night? ______________

Are you currently having any of these symptoms:

			Please explain:				Please explain:
Fever	Yes	No		Shortness of breath	Yes	No	
Chills	Yes	No		Cough	Yes	No	
Night sweats	Yes	No		Shortness of breath lying down	Yes	No	
Fatigue	Yes	No		Wheezing	Yes	No	
Weight gain	Yes	No		Shortness of breath at night	Yes	No	
Weight loss	Yes	No		Pain when swallowing	Yes	No	
Headache	Yes	No		Abdominal pain	Yes	No	
Weakness	Yes	No		Nausea	Yes	No	
Numbness	Yes	No		Vomiting	Yes	No	
Memory loss	Yes	No		Dark stools	Yes	No	
Tremor/shaking	Yes	No		Skin lesions	Yes	No	
Slurring	Yes	No		Skin rashes	Yes	No	
Chest pain	Yes	No		Cold symptoms	Yes	No	
Palpitations	Yes	No		Heat/cold intolerance	Yes	No	
Skipped beats	Yes	No		Blood in urine	Yes	No	
Back pain	Yes	No		Painful urination	Yes	No	
Neck pain	Yes	No		Urinary frequency	Yes	No	
Joint pain	Yes	No		Depression	Yes	No	
Vision changes	Yes	No		Sleep problems	Yes	No	
Hearing loss	Yes	No		Anxiety	Yes	No	
Ringing in ears	Yes	No		Hallucinations	Yes	No	

Please tell us about the medications you are on:

Medication	Dosage	Frequency

PATIENT HISTORY:

- Please describe your sleep problem:____

  ____

- Have you previously had any evaluations, sleep studies, or treatment for your sleep problem?____
- Do you ever have a restless feeling in your legs when you lie down or does anyone complain that you kick your legs at night? _______________________________________
- Do you ever fall asleep at inappropriate times? Or fall asleep easily? Describe:_______

  ____
- Do you have allergies?____
- Do you awaken with a gasping or choking sensation?______________________________
- Do you use Oxygen?_______________________Do you smoke?______________________
- Do you drink alcohol? If yes, how much and how often?___________________________
- List the amount of caffeine you have per day:_____________________________________
- Height____________ Weight_____________

EPWORTH SLEEPINESS SCALE:

Please rate how likely you would be to fall asleep during these situations:

Chance of Dozing (0-3)

0= never doze

1= slight chance of dozing

2= moderate chance of dozing

3= high chance of dozing

1. **Sitting and reading** _________________
2. **Watching TV** _________________
3. **Sitting in a public place (movie, meeting)** _________________
4. **As a passenger in a car for 1 hour** _________________
5. **Lying down to rest in the afternoon** _________________
6. **Sitting and talking to someone** _________________
7. **Sitting quietly after lunch (without alcohol)** ________________
8. **In a car while stopped in traffic** _________________

TOTAL _________________