



# Sleep Consultants, Inc.

1521 Cooper Street ♦ Fort Worth, Texas 76104 ♦ (817) 332-7433 ♦ Fax (817) 336-2159

*Comprehensive Care of Sleep Disorders  
Diagnosis, Treatment, Follow-up, Education, Research*

Patient care and business functions at 1521 Cooper Street  
Sleep Laboratory - 909 8th Avenue, Fort Worth, TX 76104  
Email: [information@sleepconsultants.com](mailto:information@sleepconsultants.com)  
Internet: <http://www.sleepconsultants.com>

**Donald E. Watenpaugh, Ph.D.**  
D, AASM, Director

**John R. Burk, M.D.**  
Medical Director

**Khosrow Behbehani, Ph.D.**  
Biomedical Engineering Consultant  
University of Texas at Arlington

**Huy X. Duong, D.O.**  
Pulmonary/Sleep Consultant

**Sami Hadeed, M.D.**  
Pediatric Pulmonology Consultant

**Sandra Knaur, APRN, BC**  
Adult Nurse Practitioner

**David Maldonado, III, M.D.**  
Pulmonary/Sleep Consultant

**Robert Odgers, Ph.D.**  
Neuropsychology Consultant

**John T. Pender, Jr., M.D.**  
Pulmonary/Sleep Consultant

**Kerim F. Razack, M.D.**  
Pulmonary/Sleep Consultant

**Michael Smith, Ph.D.**  
Physiology Consultant  
University of North Texas  
Health Science Center

Dear Patient:

\_\_\_\_\_ has an appointment with \_\_\_\_\_  
on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m. This is your initial appointment only which  
takes about an hour. If testing is needed, it will be scheduled for a later date.

We want to take this opportunity to welcome you to the practice and thank you for choosing us  
to provide your health care. We appreciate your trust in us and look forward to keeping you  
healthy.

Please complete the enclosed information BEFORE your scheduled appointment and bring the  
completed forms with requested information including current insurance card(s), all your  
medications (including inhalers, over-the-counter medications, herbs) and your CPAP or BiPAP  
machine if you are using one.

The Sleep and Health questionnaires are used to conduct this appointment so it is very important  
that this is completely filled out ahead of time. **If this is not filled out before you arrive you  
may be asked to reschedule.** It would be helpful to bring someone with you who is familiar with  
your sleep habits.

Many patients seen in our offices have sensitive respiratory conditions. Please avoid use of scented  
body spray, perfume, cologne, aftershave, or anything with a heavy scent.

If a referral is required, you will need to bring your referral and/or referral information to the  
office at the time of your visit. If we do not have this referral, you will not be seen by the doctor.  
Any services rendered by Dr. Watenpaugh, Sandy Knaur APRN, BC or Cynthia Nauman, RN,  
MSN, ACNP will be billed under Dr. John Burk with Texas Pulmonary & Critical Care  
Consultants, therefore the referral will need to be made out to Dr. John Burk. If you are scheduled  
to see Dr. Huy Duong, the referral needs to be made out to him. Any sleep testing is done at the  
909 8<sup>th</sup> Avenue location and is billed by Sleep Consultants, Inc. If you have any questions  
concerning your benefits, please call your insurance company.

**If you need to reschedule your appointment, please call us at 817-332-7433 as early as  
possible. Unless canceled at least 24 hours in advance, our policy is to charge for missed/late  
cancellation office and oximetry appointments at the rate of \$25.00 and a separate charge  
for sleep testing at the rate of \$200.00. Please help us serve you better by keeping scheduled  
appointments.**

Sincerely,

Sleep Consultants, Inc.

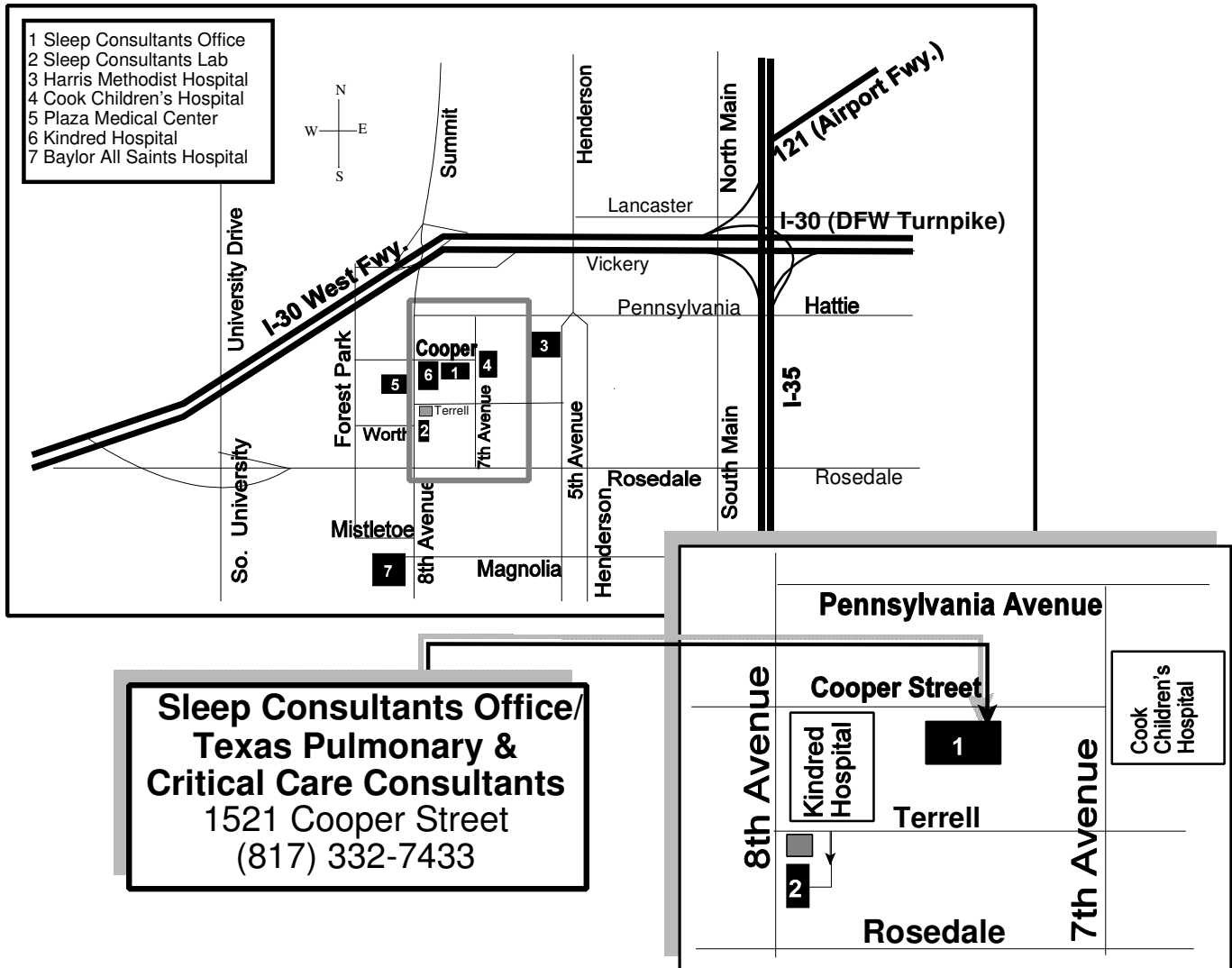


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**Sleep Consultants Office/  
Texas Pulmonary &  
Critical Care Consultants**  
1521 Cooper Street  
(817) 332-7433

## **DIRECTIONS TO SLEEP CONSULTANTS OFFICE:**

**Westbound I-30**, exit Summit/8<sup>th</sup> Avenue. Turn left at the light. (Summit becomes 8<sup>th</sup> Avenue.) At the third light, turn left on Cooper (Kindred Fort Worth West is on the corner). Turn right into the Texas Pulmonary & Critical Care Consultants/Sleep Consultants parking lot.

**Eastbound I-30**, exit Summit/8<sup>th</sup> Avenue. Turn right on Summit. (Summit becomes 8<sup>th</sup> Avenue.) At the second light, turn left on Cooper (Kindred Fort Worth West is on the corner). Turn right into the Texas Pulmonary & Critical Care Consultants/Sleep Consultants parking lot.

**I-35W Northbound/Southbound**, take the I-30 West exit. Exit Summit/8<sup>th</sup> Avenue. Turn left at the light. (Summit becomes 8<sup>th</sup> Avenue.) At the third light, turn left on Cooper (Kindred Fort Worth West is on the corner). Turn right into the Texas Pulmonary & Critical Care Consultants/Sleep Consultants parking lot.

PATIENT REGISTRATION FORM

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_  
Street City State Zip

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Religious Preference: \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Phone \_\_\_\_\_ Address \_\_\_\_\_

Referred By \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

List other physicians you are currently seeing \_\_\_\_\_

Notify in case of emergency: (Do not list anyone who lives with you)

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)  
Durable Power of Attorney: Yes No Date signed: \_\_\_\_\_ (Please provide a copy)

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

Are you currently using a DME (Durable Medical Equipment) Company? Yes No

If yes, which one? \_\_\_\_\_ Phone \_\_\_\_\_

If no, who does your insurance company require you to use? \_\_\_\_\_

Who does your insurance company require you to use for: Lab \_\_\_\_\_ X-ray \_\_\_\_\_

Is this a work-related illness? Yes No Date of illness or injury \_\_\_\_\_ Date last worked \_\_\_\_\_

Cause of accident, if any \_\_\_\_\_

Only with your written request will we release information regarding your medical condition to a family member. Do you wish information to be released to a family member? Yes No

Please list family members by name and relationship to you. \_\_\_\_\_

I hereby authorize release of my medical records from \_\_\_\_\_ to the physician(s) indicated below.

**Arlington - North**  
Joseph Austin, Jr., M.D., FCCP  
Jack G. Gilbey, Jr., M.D., FCCP  
Luis F. Guerra, M.D., FCCP  
Mitchell C. Kuppinger, M.D., FCCP  
David H. Plump, M.D., FCCP  
Tony H. Su, M.D., FCCP

**Bedford**  
Gary L. Jones, M.D., FCCP  
James T. Siminski, M.D., FCCP  
Donald L. Washington, Jr., M.D.

**Burleson**  
Dereje S. Ayo, M.D.  
Henry S. Cunningham, M.D., FCCP

**Fort Worth - Medical District 1**  
John R. Burk, M.D., FACP  
Stuart D. McDonald, M.D., FCCP  
Kerim F. Razack, M.D., FCCP

**Fort Worth - Medical District 2**  
Steven Q. Davis, M.D.  
Roger Gleason, M.D., FCCP  
John T. Pender Jr., M.D., FCCP  
David S. Hernandez, M.D.

**Fort Worth - Southwest**  
Kevin G. Connelly, M.D., FCCP  
Huy X. Duong, D.O.  
David Maldonado, III, M.D.

**Grapevine**  
R. L. "Lin" Cash, Jr., M.D., FCCP  
Timothy G. Schroeder, M.D., FCCP

**Mansfield**  
John L. Tiu, M.D.

**North Richland Hills**  
David R. Herrmann, M.D., FCCP  
Madhu S. Kollipara, M.D.

**Sleep Consultants, Inc.**  
Donald E. Watenpaugh, Ph.D.

Signature of Patient or Responsible Party

Date

## FINANCIAL POLICY

### PRIMARY INSURANCE POLICY:

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
\_\_\_\_\_ Phone No. \_\_\_\_\_

### SECONDARY INSURANCE POLICY:

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
\_\_\_\_\_ Phone No. \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance Form before seeing the doctor. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express.

#### ***Regarding Insurance***

We cannot bill your insurance company unless you give us your insurance information. If we are nonparticipating with your insurance, and they have not paid the balance within 90 days, the balance will be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. These charges will be your responsibility. Our office makes every effort to obtain referral authorizations from the Primary Care offices for patients on HMOs. Should we not be able to obtain a referral, charges will be your responsibility.

#### ***Out of Network Billing***

The physicians may not be participating physicians with your insurance plan, and if not, benefits may be reduced as such. You will be responsible for any unpaid charges and/or balances. 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 (excluding Medicare) arbitrary determination of usual and customary rates.

#### ***Missed Appointments***

**Unless canceled at least 24 hours in advance, our policy is to charge for missed office and oximetry appointments at the rate of \$25.00 and a separate charge for sleep testing at the rate of \$200.00. Please help us serve you better by keeping scheduled appointments.**

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

#### ***Research Consent***

I give permission for clinical and physiologic data from my medical records to be used for educational and research purposes. I understand that my identity and contact information (name, SS#, birth date, address, etc.) will never be attached to or processed with such data.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



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## Nurse Practitioner Consent

This facility has on staff two nurse practitioners, Sandra Knaur, APRN, BC and Cynthia Roger, RN, ACNP, BC, to assist in the delivery of pulmonary care.

A nurse practitioner is not a doctor. A nurse practitioner is a Registered Nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a nurse practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

“Supervision” does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A nurse practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical examinations
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery or procedures
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of a nurse practitioner for my health care needs.

I understand that at any time I can refuse to see the nurse practitioner and request to see a physician.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



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## Sleep Medicine Specialist Consent

This facility has on staff a sleep medicine specialist, Donald Watenpaugh, Ph.D., who is certified by the American Board of Sleep Medicine to diagnose and treat sleep disorders.

Dr. Watenpaugh is not a medical doctor. He has received advanced education and training in the provision of care for patients with sleep disorders.

I have read the above and hereby consent to the services of a sleep medicine specialist for my sleep disorder needs. I understand that at any time I can refuse to see the sleep medicine specialist and request to see a medical doctor who also specializes in sleep disorders.

\_\_\_\_\_

Name

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

**PATIENT HEALTH QUESTIONNAIRE**

To our patients: We appreciate your cooperation in completing this health status profile. We are committed to providing a thorough evaluation during your visits and you can participate today by answering the following questions as they pertain to your general health. (A member of our staff is available to assist you if you have difficulty completing this form. Questions left blank may be discussed privately with the doctor.)

If you have any of the following symptoms, please circle all that apply.

- |                |                     |                    |                                    |
|----------------|---------------------|--------------------|------------------------------------|
| cough          | spitting blood      | fever              | seizures                           |
| wheezing       | lump                | hoarseness         | indigestion/heartburn/reflux       |
| abnormal x-ray | shortness of breath | daytime sleepiness | posterior nasal drainage/sinusitis |
| sore throat    | chest pain          | insomnia           | leg twitches/discomfort            |
| snoring        |                     |                    |                                    |

**Health History:**

Have you had any health problems in these areas:

|   | DATE  | TYPE  |
|---|-------|-------|
| Mental health (i.e. depression)   | _____ | _____ |
| Epilepsy  | _____ | _____ |
| Head or nervous system  | _____ | _____ |
| Nose, throat mouth (i.e. sinus trouble, hay fever, frequent sore throats) | _____ | _____ |
| Heart, circulation, blood pressure  | _____ | _____ |
| Breathing (lungs) (i.e. wheezing, asthma, emphysema)                      | _____ | _____ |
| Tuberculosis  | _____ | _____ |
| Positive PPD  | _____ | _____ |
| Stomach, indigestion  | _____ | _____ |
| Kidneys, urine, sexual function   | _____ | _____ |
| Allergies (food, drugs, environment, etc.)                                | _____ | _____ |
| Other (i.e. diabetes, hormone abnormalities, thyroid, etc.)               | _____ | _____ |
| Previous EEGs or sleep recordings   | _____ | _____ |

Have you ever been diagnosed by a member of the medical profession as having, or have you ever received treatment from a member of the medical profession because of:

- 10. Any immune deficiency disorder including AIDS or AIDS-related complex (ARC).
- 11. Generalized lymphadenopathy syndrome (GLS).
- 12. A blood test showing evidence of antibodies to the AIDS (HTLV-III) virus.

If you circled any of the above, please provide full details. \_\_\_\_\_

**Surgical History:**

List all surgeries: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other Hospitalizations:**

\_\_\_\_\_  
 \_\_\_\_\_



List hobbies/social activities you presently enjoy:

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Family History:

|               | Age   | Medical Problems | Or | Age   | Cause of Death |
|---------------|-------|------------------|----|-------|----------------|
| Father        | _____ | _____            |    | _____ | _____          |
| Mother        | _____ | _____            |    | _____ | _____          |
| Siblings      | _____ | _____            |    | _____ | _____          |
| (Note if      | _____ | _____            |    | _____ | _____          |
| brother or    | _____ | _____            |    | _____ | _____          |
| sister)       | _____ | _____            |    | _____ | _____          |
| Children      | _____ | _____            |    | _____ | _____          |
|               | _____ | _____            |    | _____ | _____          |
|               | _____ | _____            |    | _____ | _____          |
| Grandchildren | _____ | _____            |    | _____ | _____          |
|               | _____ | _____            |    | _____ | _____          |
|               | _____ | _____            |    | _____ | _____          |

Has anyone in your family had (please circle):

Thyroid disease    Diabetes    Hypoglycemia (low blood sugar)    Tuberculosis

Has anyone in your family had sudden attacks of physical weakness or paralysis when laughing, angry, or in other emotional situations? \_\_\_\_\_

Vital statistics:    Height: \_\_\_\_\_ feet \_\_\_\_\_ inches. Neck size: \_\_\_\_\_ inches.

Weight loss or gain:    Current weight: \_\_\_\_\_    Maximum weight: \_\_\_\_\_    When: \_\_\_\_\_

| AGE | WEIGHT | AGE | WEIGHT |
|-----|--------|-----|--------|
| 20  | _____  | 50  | _____  |
| 30  | _____  | 60  | _____  |
| 40  | _____  | 70  | _____  |

Use space below for any additional comments you may wish to make about your health, intake of drugs, medicines, or alcohol.

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I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**SLEEP QUESTIONNAIRE:**

Date: \_\_\_\_\_

Please complete this questionnaire as it will help the doctor help you. As some questions are personal, you may choose to leave the answers blank and discuss them with your doctor if you wish.

Patient Name \_\_\_\_\_ Occupation \_\_\_\_\_ Age \_\_\_\_\_

Please briefly describe your sleep complaints, including when they started.

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**INSTRUCTIONS:** Please circle **Yes** or **No** or fill in blanks as indicated. Circle No if the problem is very infrequent. Place an X beside any question you do not understand or cannot answer by a simple yes or no.

1.    **Yes**   **No**    Did you have a problem with your sleep when you were younger?
2.    **Yes**   **No**    Are you unable to fall asleep at night?
3.    **Yes**   **No**    Are you unable to remain asleep at night?
4.    **Yes**   **No**    Do you commonly wake up earlier than you would like?
5.    **Yes**   **No**    Do you use an alarm clock to wake up in the morning?
6.    **Yes**   **No**    Is it easy for you to get out of bed in the morning?
7.    **Yes**   **No**    Do you feel you get too much or not enough sleep at night? (If yes, please circle which.)
8.    **Yes**   **No**    Do you feel that the quality of your sleep is unsatisfactory? (That is, no matter how much sleep you get, you do not wake up feeling rested).
9.    **Yes**   **No**    Have you ever been told you snore?
10.   **Yes**   **No**    Does your snoring disturb others in your home?
11.   **Yes**   **No**    Do you sometimes wake up choking, breathing hard, or coughing?
12.   **Yes**   **No**    Have you dreamed of drowning or being suffocated?
13.   **Yes**   **No**    Do you wake up at night with heartburn?
14.   **Yes**   **No**    Do you sweat excessively during sleep?
15.   **Yes**   **No**    Do you commonly wake up in the morning with a sore throat or hoarseness?
16.   **Yes**   **No**    Do you wake up in the morning with a headache?
17.   **Yes**   **No**    Is your sleep often "restless" and "disturbed"?
18.   **Yes**   **No**    Do you get an uncomfortable, hard-to-describe feeling in your legs or elsewhere that increases in intensity?
19.   **Yes**   **No**    Do these symptoms worsen when sitting or lying down, especially in the late evening or night?
20.   **Yes**   **No**    Does this feeling create a demanding need to move the legs or body to relieve the feeling?
21.   **Yes**   **No**    Do you get relief of these symptoms by activity (walking, stretching, bending) at least temporarily?
22.   **Yes**   **No**    Are you bothered by itching sensations during the night?
23.   **Yes**   **No**    Does pain disturb your sleep? If yes, please describe: \_\_\_\_\_
24.   **Yes**   **No**    Do you have hallucinations or dream-like mental images during the day?
25.   **Yes**   **No**    Do you have attacks of sudden physical weakness or paralysis during the day?
26.   **Yes**   **No**    If so, do laughing, anger, or other emotional factors trigger the attacks?
27.   **Yes**   **No**    Do you have hallucinations or dream-like mental images when you are falling asleep or waking up?
28.   **Yes**   **No**    Do you ever feel paralyzed when falling asleep or as you are waking up?

29. **Yes No** Do you often have frightening dreams or nightmares?
30. **Yes No** Do you ever wake up screaming?
31. **Yes No** Are you afraid of the dark or of going to sleep?
32. **Yes No** Do you awaken during the night or in the morning with feelings of fear, anxiety, worry, depression, unhappiness, irritability, or confusion? (Please circle those that apply.)
33. **Yes No** Do you tend to lie awake at night with thoughts racing through your mind?
34. **Yes No** Do you sleep walk?
35. **Yes No** Do you talk in your sleep?
36. **Yes No** Do you grind your teeth during sleep?
37. **Yes No** Do you wake up with pain in your jaws?
38. **Yes No** Do you bang your head against the bed or wall?
39. **Yes No** Do you make rolling/rocking movements in sleep?
40. **Yes No** Do you fall out of bed?
41. **Yes No** Do you eat or drink anything, or take any medications *during* the night (*after* going to bed)? If so, what? \_\_\_\_\_
42. **Yes No** Do you usually sleep with someone (sibling)?
43. **Yes No** Are you awake at night because of your bed partner (because of your partner's noise or movement)?
44. **Yes No** Are you awake during the night because some other person or animal requires assistance?
45. **Yes No** Are you awake at night because of noise, heat, cold, or light?
46. **Yes No** Do you rely on caffeine (coffee, tea, etc.) to stay awake during the day?
47. **Yes No** Do you feel physically fatigued or tired during the day even when you are not sleepy?
48. **Yes No** Is your daytime performance in school, work or recreation less efficient than you would like it to be?
49. **Yes No** Do you yawn very frequently during the day?
50. **Yes No** Do you feel distracted and unable to concentrate during the day?
51. **Yes No** If you take stimulants, do you feel your performance is satisfactory when taking them?
52. **Yes No** Have you ever "come to" and discovered that you have performed some complex activity (i.e. driving car) without remembering it (blackouts)?
53. Do you fall asleep during these situations? (*Rate your chance of dozing: 0=never, 1=slight, 2=moderate, 3=high*)
- \_\_\_\_\_ Sitting and reading
- \_\_\_\_\_ Watching TV
- \_\_\_\_\_ Sitting inactive in a public place (e.g. a theater or meeting)
- \_\_\_\_\_ As a passenger in a car for an hour without a break
- \_\_\_\_\_ Lying down to rest in the afternoon when circumstances permit
- \_\_\_\_\_ Sitting and talking to someone
- \_\_\_\_\_ Sitting quietly after a lunch without alcohol
- \_\_\_\_\_ In a car, while stopped for a few minutes in traffic
54. **Yes No** Do you have uncontrollable urges to fall asleep during the day or find yourself falling asleep when you do not want to?
55. **Yes No** Have you had accidents or near accidents when driving a car because you felt extremely sleepy or were having trouble concentrating?
56. Do you function most poorly in the morning, afternoon, or evening? (Please circle which.)
57. List anything else (not yet covered) which especially interferes with your sleep.
- \_\_\_\_\_
- \_\_\_\_\_

58. List things that make daytime or nighttime symptoms and complaints worse.

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59. List things that make daytime or nighttime symptoms and complaints better.

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*(If you completed the attached sleep diary, you can skip questions 62-69.)*

60. Usual bedtime on workdays \_\_\_\_ a.m./p.m. Days off \_\_\_\_ a.m./p.m.

61. How long does it take to go to sleep on workdays? \_\_\_\_ minutes. Days off \_\_\_\_ minutes

62. Usual time to get up on workdays \_\_\_\_ a.m./p.m. Days off \_\_\_\_ a.m./p.m.

63. How much sleep do you feel you get each night? \_\_\_\_ hours

64. Number of awakenings per night \_\_\_\_ How long do you stay awake? \_\_\_\_

65. Number of bathroom trips per night \_\_\_\_

66. How long does it take you to become fully alert and functional in the morning? \_\_\_\_

67. If you take naps, how long are they (Include dozing while watching TV, reading, etc.)? \_\_\_\_

What time of day? \_\_\_\_\_ How many naps per week? \_\_\_\_\_

68. Is there a particular sleep/wake schedule you would prefer to your present schedule, but have difficulty achieving it? If yes, please explain. (For example, I would like to fall asleep earlier, sleep for nine hours, and wake up earlier.)

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69. **Yes No** Do you have any regular physical activity or exercise? If so, please describe (type of activity, frequency, etc.) \_\_\_\_\_

70. **Yes No** Do you eat a meal within two hours of going to bed?

71. **Yes No** Are you claustrophobic?

72. **Yes No** Is your nose commonly congested or stuffy?

73. **Yes No** Does your pulse ever beat too fast or too hard (palpitations) during the day or night?

74. **Yes No** Are you short of breath during the day?

75. **Yes No** Do your ankles swell up during the day?

76. **Yes No** Do you have significant muscular weakness?

77. **Yes No** Have you ever had a significant injury to your head?

78. **Yes No** Do you suffer from fainting spells or loss of consciousness during the day?

79. **Yes No** Do you ever have double vision or blurred vision?

80. **Yes No** WOMEN Do you have daytime complaints that vary with the stage of your menstrual cycle?

81. **Yes No** WOMEN Are your menstrual periods in any way abnormal or irregular?

82. **Yes No** WOMEN Are you pregnant?

83. **Yes No** MEN Do you wake up with penile erections that are painful?

84. **Yes No** Do you have sleep complaints that seem to go in cycles or only appear at certain times? Examples: only in the evening, every 10 days, when you sleep away from home, etc.) If so, please explain: \_\_\_\_\_

85. **Yes No** Have you ever considered or attempted suicide?

86. **Yes No** Do you frequently feel depressed, fearful, anxious, worried, irritable, disoriented or confused during the day? (Circle those that apply.)

87. **Yes No** Have you ever had treatment/therapy by a psychiatrist or clinical psychologist?

- 88. **Yes No** Do you have severe headaches or migraines during the day?
- 89. **Yes No** Do you tend to have uncontrollable eye flickering?
- 90. **Yes No** Do your eyes burn or tear during the day?
- 91. **Yes No** Have you or any of your family or relatives been diagnosed with hyperactivity or attention deficit problems?
- 92. **Yes No** Do you feel that you are living under unusual "pressure" or "stress" at this time?
- 93. Are there any other daytime symptoms or complaints which you feel may be related to sleep? If yes, please explain.

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- 94. Is there any other complaint, sensation, or problem that bothers you during the day, whether or not it may be associated with sleep? If yes, please explain.

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- 95. Does anyone in your family have sleep problems? If yes, please explain.

\_\_\_\_ Brother or Sister \_\_\_\_\_

\_\_\_\_ Father or Mother \_\_\_\_\_

\_\_\_\_ Other family member \_\_\_\_\_

- 96. Does anyone in your family have psychiatric problems? If yes, please explain.

\_\_\_\_ Brother or Sister \_\_\_\_\_

\_\_\_\_ Father or Mother \_\_\_\_\_

\_\_\_\_ Other family member \_\_\_\_\_

- 97. How much of these beverages do you consume, on average? Place a 0 in blank if none.

Caffeinated Coffee: \_\_\_\_ cups/day, including \_\_\_\_ cups after 6 p.m.

Caffeinated Tea (hot or cold): \_\_\_\_ glasses/day, including \_\_\_\_ glasses after 6 p.m.

Caffeinated soda: \_\_\_\_ cans/bottles/day, including \_\_\_\_ cans/bottles/after 6 p.m.

Beer, wine, liquor (circle all that apply)

\_\_\_\_ drinks / day before 6 p.m.      \_\_\_\_ drinks / day after 6 p.m.      \_\_\_\_ drinks / day at bedtime

- 98. If you take medications, which ones do you take in the evening or before bedtime? Please list, and circle those you take specifically to help you sleep.

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I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature \_\_\_\_\_

Date \_\_\_\_\_

If not filled out by patient, please print name and relationship to patient:

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## BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Pick out the *one* statement in each group which best describes the way you have been feeling the PAST WEEK (including TODAY). Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all of the statements in each group before making your choice.

1. 0 I do not feel sad  
1 I feel sad  
2 I am sad all the time & I can't snap out of it  
3 I am so sad or unhappy that I can't stand it
2. 0 I am not particularly discouraged about the future  
1 I feel discouraged about the future  
2 I feel I have nothing to look forward to  
3 I feel that the future is hopeless & that things cannot improve
3. 0 I don't feel like a failure  
1 I feel I have failed more than the average person  
2 As I look back on my life, all I can see are a lot of failures  
3 I feel I am a complete failure as a person
4. 0 I get as much satisfaction out of things as I used to  
1 I don't enjoy things the way I used to  
2 I don't get real satisfaction out of anything anymore  
3 I am dissatisfied or bored with everything
5. 0 I don't feel particularly guilty  
1 I feel guilty a good part of the time  
2 I feel quite guilty most of the time  
3 I feel guilty all of the time
6. 0 I don't feel I am being punished  
1 I feel I may be punished  
2 I expect to be punished  
3 I feel I am being punished
7. 0 I don't feel disappointed in myself  
1 I am disappointed in myself  
2 I am disgusted with myself  
3 I hate myself
8. 0 I don't feel I am any worse than anybody else  
1 I am critical of myself for my weaknesses or mistakes  
2 I blame myself all the time for my faults  
3 I blame myself for everything bad that happens
9. 0 I don't have any thoughts of killing myself  
1 I have thoughts of killing myself, but would not carry them out  
2 I would like to kill myself  
3 I would kill myself if I had the chance
10. 0 I don't cry any more than usual  
1 I cry more now than I used to  
2 I cry all of the time now  
3 I used to be able to cry, but now I can't even though I want to
11. 0 I am no more irritated now than I ever am  
1 I get annoyed or irritated more easily than I used to  
2 I feel irritated all of the time now  
3 I don't get irritated at all by the things that used to irritate me
12. 0 I have not lost interest in other people  
1 I am less interested in other people than I used to be  
2 I have lost most of my interest in other people  
3 I have lost all of my interest in other people
13. 0 I make decisions about as well as I ever could  
1 I put off making decisions more than I used to  
2 I have greater difficulty in making decisions than before  
3 I can't make decisions at all anymore
14. 0 I don't feel I look any worse than I used to  
1 I am worried that I am looking old or unattractive  
2 I feel that there are permanent changes in my appearance that make me look unattractive  
3 I believe that I look ugly
15. 0 I can work about as well as before  
1 It takes an extra effort to get started at doing something  
2 I have to push myself very hard to do anything  
3 I can't do any work at all
16. 0 I can sleep as well as usual  
1 I don't sleep as well as I used to  
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep  
3 I wake up several hours earlier
17. 0 I don't get more tired than usual  
1 I get tired more easily than I used to  
2 I get tired from doing almost anything  
3 I am too tired to do anything
18. 0 My appetite is no worse than usual  
1 My appetite is not as good as it used to be  
2 My appetite is much worse now  
3 I have no appetite at all anymore
19. 0 I haven't lost much weight, if any, lately  
1 I have lost more than 5 pounds  
2 I have lost more than 10 pounds  
3 I have lost more than 15 pounds  
(I am trying to lose weight by eating less YES NO )
20. 0 I am no more worried about my health than usual  
1 I am worried about physical problems such as aches & pains, upset stomach or constipation  
2 I am very worried about physical problems & its hard to think about much else  
3 I am so worried about physical problems that I cannot think about anything else
21. 0 I have not noticed a recent change in my interest in sex  
1 I am less interested in sex than I used to be  
2 I am much less interested in sex now  
3 I have lost interest in sex completely

If you drink alcohol, please answer the following by circling YES or NO

1. Have you ever felt you ought to cut down on your drinking? YES NO
2. Have people annoyed you by criticizing your drinking? YES NO
3. Have you ever felt bad or guilty about your drinking? YES NO
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener) YES NO

PATIENT'S NAME: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

SCORE: \_\_\_\_\_

# Sleep Diary

Sleep Consultants Inc.

New Patient Paperwork-TEEN.wpd 6/11/02

Name: \_\_\_\_\_

|   | Date _____<br>Sunday | Date _____<br>Monday | Date _____<br>Tuesday | Date _____<br>Wednesday | Date _____<br>Thursday | Date _____<br>Friday | Date _____<br>Saturday |
|---|----------------------|----------------------|-----------------------|-------------------------|------------------------|----------------------|------------------------|
| What time did you go to bed last night?                                   |                      |                      |                       |                         |                        |                      |                        |
| How long did it take you to fall asleep last night in minutes?            |                      |                      |                       |                         |                        |                      |                        |
| How many times did you wake up? At what time(s)? For how long?            |                      |                      |                       |                         |                        |                      |                        |
| What time did you wake up this morning? What time did you get out of bed? |                      |                      |                       |                         |                        |                      |                        |
| How did you feel this morning?  |                      |                      |                       |                         |                        |                      |                        |
| Did you take any naps today? At what time(s)? For how long?               |                      |                      |                       |                         |                        |                      |                        |
| Did you drink any coffee, tea or cola drinks? How much? At what time(s)?  |                      |                      |                       |                         |                        |                      |                        |
| Did you drink any alcohol today? How much? At what times?                 |                      |                      |                       |                         |                        |                      |                        |

# Sleep Diary

Sleep Consultants Inc.

New Patient Paperwork-TEEN.wpd 6/11/02

Name: \_\_\_\_\_

|   | Date _____<br>Sunday | Date _____<br>Monday | Date _____<br>Tuesday | Date _____<br>Wednesday | Date _____<br>Thursday | Date _____<br>Friday | Date _____<br>Saturday |
|---|----------------------|----------------------|-----------------------|-------------------------|------------------------|----------------------|------------------------|
| What time did you go to bed last night?                                   |                      |                      |                       |                         |                        |                      |                        |
| How long did it take you to fall asleep last night in minutes?            |                      |                      |                       |                         |                        |                      |                        |
| How many times did you wake up? At what time(s)? For how long?            |                      |                      |                       |                         |                        |                      |                        |
| What time did you wake up this morning? What time did you get out of bed? |                      |                      |                       |                         |                        |                      |                        |
| How did you feel this morning?  |                      |                      |                       |                         |                        |                      |                        |
| Did you take any naps today? At what time(s)? For how long?               |                      |                      |                       |                         |                        |                      |                        |
| Did you drink any coffee, tea or cola drinks? How much? At what time(s)?  |                      |                      |                       |                         |                        |                      |                        |
| Did you drink any alcohol today? How much? At what times?                 |                      |                      |                       |                         |                        |                      |                        |

Begin completing the diary on the day that you receive it. After completing one side turn it over and continue on the opposite side.

**OVER**

**SLEEP CONSULTANTS, Inc.**  
**1521 Cooper Street**  
**Fort Worth, Texas 76104**  
**(817) 332-7433**

**ASSESSMENT OF PATIENT'S BEHAVIOR BY BED PARTNER OR FAMILY MEMBER**

Please answer the following questions about the patient's behavior over the past *six months* by circling the word that reflects your opinion.

- |   |       |        |           |       |        |
|---|-------|--------|-----------|-------|--------|
| 1. Snores loudly .....                                      | never | rarely | sometimes | often | always |
| 2. Keeps you awake by loudly snoring .....                  | never | rarely | sometimes | often | always |
| 3. Snores loudly in all positions .....                     | never | rarely | sometimes | often | always |
| 4. Snoring results in you sleeping separately .....         | never | rarely | sometimes | often | always |
| 5. Breathing pauses and/or snorts are heard .....           | never | rarely | sometimes | often | always |
| 6. Body movements (e.g. legs, arms, body jerks, etc.) ..... | never | rarely | sometimes | often | always |
| 7. Grinding teeth .....                                     | never | rarely | sometimes | often | always |
| 8. Acting out dreams .....                                  | never | rarely | sometimes | often | always |
| 9. Sleep onset within 5 minutes or less .....               | never | rarely | sometimes | often | always |
| 10. Poor concentration and/or short term memory .....       | never | rarely | sometimes | often | always |
| 11. Increased irritability and quick temper .....           | never | rarely | sometimes | often | always |

Please estimate the likelihood of your bed partner falling asleep in the following common situations.

0 = never    1 = slight    2 = moderate    3 = high    N/A = no chance to observe or form an opinion

- 12. \_\_\_\_\_ Sitting and reading.
- 13. \_\_\_\_\_ Watching television.
- 14. \_\_\_\_\_ Sitting inactive in a public place (e.g. a theater or meeting).
- 15. \_\_\_\_\_ As a passenger in a car for an hour without a break.
- 16. \_\_\_\_\_ Lying down to rest in the afternoon when circumstances permit.
- 17. \_\_\_\_\_ Sitting and talking to someone.
- 18. \_\_\_\_\_ Sitting quietly after a lunch without alcohol.
- 19. \_\_\_\_\_ In a car while stopped for a few minutes in traffic.

\_\_\_\_\_ Total of 12-19

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Person Completing Questionnaire: \_\_\_\_\_

Relationship: \_\_\_\_\_

# Appointment of Authorized Representative

## 1. Identifying Information

Patient's name \_\_\_\_\_

Member's name \_\_\_\_\_

Member's address \_\_\_\_\_

Member's plan identification # \_\_\_\_\_

Provider's plan identification # \_\_\_\_\_

Service not paid / not authorized by plan \_\_\_\_\_

Date(s) of service \_\_\_\_\_

2. **Appointment.** I, \_\_\_\_\_, appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as my authorized representative in requesting an appeal from \_\_\_\_\_ regarding its denial of services / denial of payment.

3. **Directed payment.** I agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to my authorized representative, and direct the plan to do so in that event.

4. **Member's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

5. **Witness's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA



CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

# HEALTH INSURANCE CLAIM FORM

PICA PICA

|   |   |   |
|---|---|---|
| 1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER<br><input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID) | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)   |   |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)   | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)   |
| 5. PATIENT'S ADDRESS (No., Street)  | 6. PATIENT RELATIONSHIP TO INSURED<br>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>   | 7. INSURED'S ADDRESS (No., Street)  |
| CITY STATE  | 8. PATIENT STATUS<br>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/><br>Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>   | CITY STATE  |
| ZIP CODE TELEPHONE (Include Area Code) ( )  | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)   | ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER   | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (CURRENT OR PREVIOUS)<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? PLACE (State)<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>c. OTHER ACCIDENT?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | 11. INSURED'S POLICY GROUP OR FECA NUMBER   |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   | 10d. RESERVED FOR LOCAL USE   | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |
| c. EMPLOYER'S NAME OR SCHOOL NAME   | 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br>SIGNED <b>X</b> DATE  | b. EMPLOYER'S NAME OR SCHOOL NAME   |
| d. INSURANCE PLAN NAME OR PROGRAM NAME  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br>SIGNED <b>X</b>  | c. INSURANCE PLAN NAME OR PROGRAM NAME  |
| <b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>   |   |   |
| 14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)   | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY  | d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.               |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE   | 17a. I.D. NUMBER OF REFERRING PHYSICIAN   | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. |
| 19. RESERVED FOR LOCAL USE  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY   | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)   | 20. OUTSIDE LAB? \$ CHARGES<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.  |
| 1. _____ 3. _____   | 23. PRIOR AUTHORIZATION NUMBER  | 23. PRIOR AUTHORIZATION NUMBER  |
| 2. _____ 4. _____   | 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCCPS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE                                       |   |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN   | 26. PATIENT'S ACCOUNT NO.   | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 28. TOTAL CHARGE \$   | 29. AMOUNT PAID \$  | 30. BALANCE DUE \$  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  | 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)  | 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #   |
| SIGNED DATE   | PIN#  | GRP#  |

Texas Pulmonary & Critical Care Consultants, P.A.  
Sleep Consultants, Inc.  
Acknowledgment of Review of  
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

---

Name of Patient or Personal Representative

---

Description of Personal Representative's Authority