



2941 OAK PARK CIRCLE, SUITE 200 • FORT WORTH, TEXAS 76109
(817) 332-7433 • FAX (817) 394-6282

1201 FAIRMOUNT AVENUE • FORT WORTH, TEXAS 76104
(817) 335-5288 • FAX (817) 338-0927

6100 HARRIS PKWY, STE. 285 • FORT WORTH, TEXAS 76132
(817) 263-5864 • FAX (817) 263-3791

*Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research*

Sleep Laboratory – 2941 Oak Park Circle, Ste. 200, Fort Worth, TX 76109
Email: Information@SleepConsultants.com
Internet: <http://www.SleepConsultants.com>

_____ has an appointment with _____ on _____ at _____ with a check-in time of _____. 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 Cynthia Roger, RN, 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. Any sleep testing is done in one of our sleep laboratories and is billed by Texas Pulmonary & Critical Care Consultants. If you have any questions concerning your benefits, please call your insurance company.

If you need to reschedule your appointment, please call us at 817-335-5288 as early as possible. Please help us serve you better by keeping scheduled appointments.

Sincerely,

Sleep Consultants, Inc.



2941 OAK PARK CIRCLE, SUITE 200 • FORT WORTH, TEXAS 76109
(817) 332-7433 • FAX (817) 394-6282

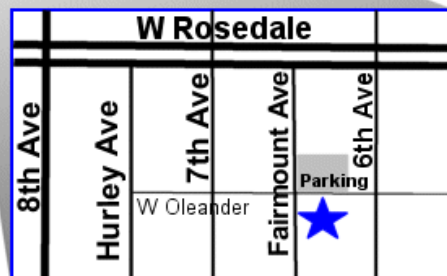
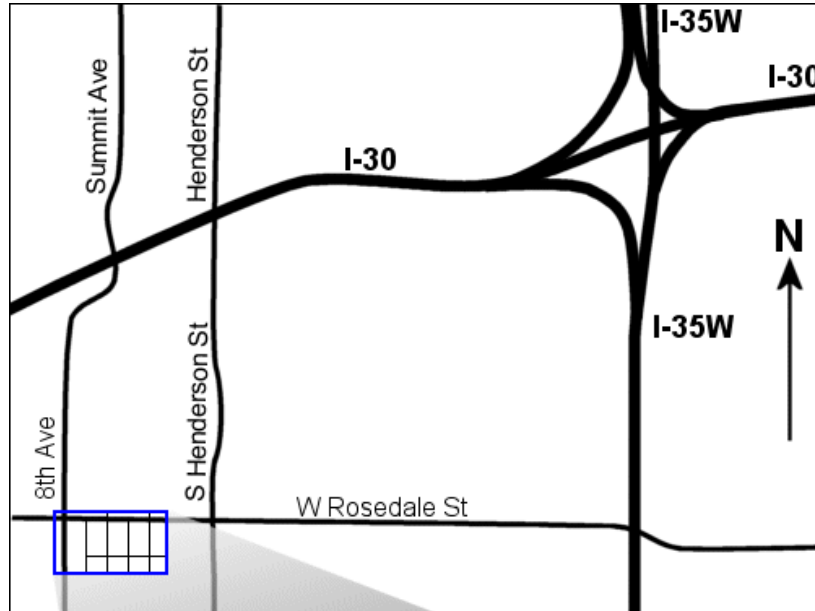
1201 FAIRMOUNT AVENUE • FORT WORTH, TEXAS 76104
(817) 335-5288 • FAX (817) 338-0927

6100 HARRIS PKWY, STE. 285 • FORT WORTH, TEXAS 76132
(817) 263-5864 • FAX (817) 263-3791

*Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research*

Sleep Laboratory – 2941 Oak Park Circle, Ste. 200, Fort Worth, TX 76109
Email: Information@SleepConsultants.com
Internet: <http://www.SleepConsultants.com>

1201 Fairmount Avenue
Fort Worth, TX 76104
817.335.5288



DIRECTIONS:

Heading North/Southbound on I-35W, take the W Rosedale Street exit. Head west on Rosedale. Drive approximately 18 blocks. You cannot turn left on Fairmount from Rosedale going west. Either turn left on 6th Avenue, then right on W Oleander Street, or make a U-turn on 8th Avenue and turn right on Fairmount. Park in the lot at the northeast corner of W Oleander Street and Fairmount, just north of our building.

East/Westbound I-30, exit Summit/8th Avenue. Turn south on Summit. (Summit becomes 8th Avenue.) Turn left on W Rosedale Street. Turn right on Fairmount Avenue. Park in the lot at the northeast corner of W Oleander Street and Fairmount, just north of our building.

SLEEP CONSULTANTS PATIENT QUESTIONNAIRE

Thank you for completing this questionnaire. Your answers enable us to provide a thorough evaluation. If you have any of the following symptoms or medical problems, or if you take medications or therapy for the symptom/problem, please circle items or fill in blanks as appropriate:

- | | | | |
|--|---|-----------------------------------|---------------------|
| Feeling poorly, ill | Double vision | Blurred vision | Wear glasses |
| Wear contact lenses | Sleep with contacts in? yes no | Glaucoma | Headaches |
| Migraine | Insomnia | Dizziness | Fainting |
| Epilepsy / seizures | Neuropathy | Restless legs syndrome | Memory problems |
| Dementia | Stroke / TIA | Depression | Anxiety |
| ADD / ADHD | Autism | Short temper | Claustrophobia |
| PTSD | Other mood disorder / mental illness: _____ | | Runny nose |
| Stuffy nose | Post-nasal drainage | Sinus trouble | Nosebleeds |
| Sore throat | Hoarseness | Dental problems: _____ | |
| Wear dentures: upper lower both | Sleep with dentures in? yes no | Rapid weight gain or loss | |
| Change in appetite | Indigestion/Heartburn | Reflux | Abdominal pain |
| Difficulty swallowing | Nausea | Vomiting | Constipation |
| Diarrhea | Bloody stools | High blood pressure | Ankle swelling |
| Racing heart | Irregular heartbeat / palpitations | | Atrial fibrillation |
| Chest pain | Coronary artery disease | Congestive heart failure | Cough |
| Wheezing | Shortness of breath at rest | Shortness of breath with activity | Asthma |
| COPD | Emphysema | Coughing up blood | Sleep apnea |
| Previous sleep studies (when/where): _____ | | Inactive / sedentary | Obese |
| Diabetes: type 1 or 2 | Hypoglycemia | Cold / heat intolerance | Thyroid disease |
| Other hormone abnormalities: _____ | | General weakness | |
| Localized muscle weakness | Chronic fatigue syndrome | Osteoporosis | Renal failure |
| On dialysis | Difficulty urinating | Prostate enlargement | |
| Frequent urinary tract infections | Incontinence | Disinterest in sex | |
| Erectile dysfunction | Other sexual dysfunction _____ | | |
| Cancer: type / location? _____ | In remission? yes no | Muscle aches | |
| Low back pain | Fibromyalgia | Other chronic pain: _____ | |
| Rash | Fever | Hepatitis | |
| Tuberculosis or positive PPD test | HIV-positive | AIDS | |
| Other infectious disease(s): _____ | Mental disability | Physical disability | |

Surgical History – Please list all surgeries and the year they were performed:

Hospitalizations and Emergency room visits – Please include reason and year:

Dental/orthodontic history – Please include procedure and year:

Please list all prescription medications you take. Continue on the back if needed, or bring a list with you.

Medication	Dose	Time of day taken	Reason	Length of time used	Prescribing physician

List all non-prescription drugs, vitamins, and supplements you take:

Medication	Dose	Time of day taken	Reason	Length of time used	Prescribing physician

Please list all allergies or intolerance / adverse reactions:

Medications: _____
 Foods: _____
 Environment, etc.: _____

Date of last flu shot: _____ Date of last pneumonia vaccination: _____

Tobacco / nicotine history:

Do you smoke? **Yes No** If yes, how many packs per day? ____ For how many years? ____
 If you smoked in the past, how many packs per day? ____ For how many years? ____ Quit in? ____
 Do you chew tobacco? **Yes No** If yes, how many cans per week? ____ For how many years? ____
 Quit chewing tobacco in (year)? _____ Do you currently use an electronic cigarette? **Yes No**
 Exposure to second-hand tobacco smoke (circle): Never/rarely Occasionally Often Regularly

How many caffeinated beverages do you consume per day, on average? _____
Of those, how many do you consume after 4 PM? _____

Alcohol consumption - drinks per week:

Beer _____ Wine _____ Mixed Drinks _____ Hard Liquor _____

Do you drink every day? **Yes No**

Do you drink before bedtime specifically to help you sleep? **Yes No**

Are you ever hungover from drinking? **Yes No**

Have you or others ever felt that you should decrease your drinking? **Yes No**

Substance abuse now or in the past (circle):

Prescription drugs Marijuana Cocaine Narcotics Recreational drugs IV drugs

Do you have regular physical activity or exercise? **Yes No** If yes, please describe type of activity, frequency, etc.: _____

List hobbies and social activities you enjoy:

<u>Age</u>	<u>Weight</u>	<u>Age</u>	<u>Weight</u>
20	_____	50	_____
30	_____	60	_____
40	_____	70	_____

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

Do you feel you are living with unusual stress at this time? **Yes No**

If yes, please explain: _____

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

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

Are you pregnant? **Yes No**

Are you past menopause, or are you having menopausal symptoms now? **Yes No**

Use space below for any additional comments about your health or medical history:

Family Medical History (please list all known medical problems, including sleep and psychiatric problems):

Mother _____

Father _____

Siblings _____

(Note if _____

sister or _____

brother) _____

Children _____

(Note if _____

daughter _____

or son) _____

Other _____

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.

-
-
1. **Yes No** Did you have a problem with your sleep as a child? If yes, please describe: _____
 2. **Yes No** Are you unable to fall asleep at night?
 3. **Yes No** Are you unable to remain asleep at night, or do you often wake up earlier than you would like?
 4. **Yes No** Do you take, or have you ever taken, any medications or other substances to help you sleep? If yes, please list, and describe how well they work: _____
-
5. **Yes No** Do you toss and turn a lot, or have difficulty getting comfortable in bed?
 6. **Yes No** Do you sleep with a TV or radio on?
 7. **Yes No** Do you use a computer, cell phone, or other electronic device before bed or during the night?
 8. **Yes No** Do you lie awake at night with thoughts racing through your mind?
 9. **Yes No** Are you afraid of the dark or of going to sleep?
 10. **Yes No** Do you get an uncomfortable, hard-to-describe feeling in your legs or elsewhere accompanied by a strong urge to move?
 11. **Yes No** Do these symptoms begin or worsen when sitting or lying down?
 12. **Yes No** Does movement (stretching, bending, walking) temporarily relieve the symptoms?
 13. When do the symptoms occur (circle which)? morning afternoon evening night
 14. **Yes No** Do you itch at night?
 15. **Yes No** Do you ever wake up with chest pain or palpitations?
 16. **Yes No** Does other pain disturb your sleep? If yes, please describe:
 17. **Yes No** Do you grind or clench your teeth during sleep?
 18. **Yes No** Do you wake up with jaw pain?
 19. **Yes No** Do you feel you get too much or not enough sleep? (If yes, please circle which.)
 20. **Yes No** Do you feel your sleep quality is poor? (That is, no matter how much sleep you get, you do not wake up feeling rested).
 21. **Yes No** Do you commonly breathe through your mouth, especially at night?
 22. **Yes No** Have you ever been told you snore?
 23. **Yes No** Does your snoring disturb others?
 24. **Yes No** Has anyone ever told you that you stop breathing during sleep?
 25. **Yes No** Do you sometimes wake up choking, breathing hard, coughing, or gasping for breath?
 26. **Yes No** Have you dreamed of drowning or being suffocated?
 27. **Yes No** Do you wake up at night with heartburn?
 28. **Yes No** Do you sweat excessively during sleep?
 29. **Yes No** Do you commonly wake up in the morning with a sore throat or hoarseness?
 30. **Yes No** Do you wake up in the morning with a headache?
 31. **Yes No** Have you wet the bed during sleep as an adult?
 32. **Yes No** Do you often have frightening dreams or nightmares?

33. **Yes No** Do you ever wake up screaming?
34. **Yes No** Have you ever been told that you make rolling/rocking movements in sleep?
35. **Yes No** Have you ever been told that you act out dreams?
36. **Yes No** Do you awaken during the night or in the morning with feelings of sadness, fear, anxiety, worry, irritability, anger, disorientation, or confusion? (Please circle all that apply.)
37. **Yes No** Do you sleep walk or engage in other activity while asleep?
38. **Yes No** Do you talk in your sleep?
39. **Yes No** Do you fall out of bed?
40. **Yes No** Do you eat a meal within two hours of going to 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?
43. **Yes No** Are you awake at night because of your bed partner's noise or movement?
44. **Yes No** Do you think your bed partner may have a sleep disorder?
45. **Yes No** Are you awake at night to assist a person or animal?
46. **Yes No** Are you awake at night because of noise, heat, cold, or light? (Circle which)
47. **Yes No** Do you have hallucinations or dream-like states as you fall asleep or wake up? If yes, circle which.
48. **Yes No** Do you ever feel paralyzed when falling asleep or waking up? If yes, circle which.
49. **Yes No** Do you use an alarm clock to wake up?
50. **Yes No** MEN: Do you wake up with penile erections?
51. **Yes No** Is it easy for you to get out of bed in the morning?
52. **Yes No** Do you rely on caffeine (coffee, tea, etc. the) to stay awake during the day?
53. **Yes No** Do you have sudden attacks of physical weakness or paralysis during the day?
54. **Yes No** If so, do laughing, anger, or other emotional factors trigger the attacks?
55. **Yes No** Do you feel tired or physically fatigued during the day even when you are not sleepy?
56. **Yes No** Is your daytime performance in work or recreation less efficient than you would like?
57. **Yes No** Do you yawn frequently during the day?
58. **Yes No** Do your eyes burn or tear during the day?
59. **Yes No** Do you feel distracted and unable to concentrate?
60. **Yes No** Do you frequently feel depressed, fearful, anxious, worried, irritable, angry, disoriented or confused during the day? (Please circle all that apply.)
61. **Yes No** Have you ever "come to" and discovered that you have performed a complex activity (i. e. driving a car) without remembering it (blackouts)?
62. Rate your chance of dozing in the following situations, with 0 = never, 1 = slight, 2 = moderate, and 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
63. **Yes No** Do you have uncontrollable urges to sleep during the day or fall asleep unintentionally?
64. **Yes No** Have you had accidents or close calls while driving because you were sleepy or "foggy"?

65. **Yes No** Does your occupation involve shift-work, night-work or travel across time zones? If yes, please describe, including whether or not you keep the same schedule on days off from work:

66. **Yes No** Do your sleep problems occur in cycles or only at certain times? (Examples: every 10 days, only when away from home, women: during your period, etc.) If yes, please explain:

67. **Yes No** Do you commonly sleep in locations other than a bed in a bedroom? If yes, please indicate where: couch recliner floor elsewhere _____
68. Do you function most poorly in the morning, afternoon, or evening? (Please circle which.)
69. List things that make daytime or nighttime symptoms and complaints worse.

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

71. In what position(s) do you prefer to sleep? Circle:
supine (on back) right side left side prone (on stomach) in recliner
72. Usual bedtime: _____ AM / PM If different on days off: _____ AM / PM
73. How long does it take you to go to sleep? _____
74. Usual wake time: _____ AM / PM If different on days off: _____ AM / PM
75. How much sleep do you feel you get each night? _____ hours
76. Number of awakenings per night: _____ How long do you stay awake? _____
77. Number of bathroom trips per night: _____
78. How long does it take you to become fully alert and functional in the morning? _____
79. If you take naps, how long are they (include even brief dozing while watching TV, reading, etc.)? _____
What time of day? _____ How many naps per week? _____
80. Describe anything about your sleep/wake schedule that you dislike? _____

81. Is there a sleep/wake schedule you would prefer to your present schedule, but have difficulty achieving?

82. Do you have any other daytime symptoms or complaints which you feel may be related to sleep? If yes, please explain: _____

I certify that all information is correct and complete. If any information changes, I will notify Sleep Consultants, Inc.

Signature _____ Date _____

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

SLEEP CONSULTANTS, Inc.
1201 Fairmount Avenue
Fort Worth, Texas 76104
(817) 335-5288

ASSESSMENT OF PATIENT'S BEHAVIOR BY BED PARTNER

Please answer the following questions about your bed partner'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: _____

PATIENT REGISTRATION FORM

Date: _____

SSN _____

Sex _____

Employment Status Employed Disabled
 Self Employed Retired
 Unemployed Student

Name:

First _____

Employer _____

Middle _____

Employer phone _____

Last _____

Birth Date _____

Preferred Name _____ Suffix _____ Marital Status _____


Race _____ Ethnicity: Latino/Hispanic Not Hispanic or Latino Other Decline to Answer



Language _____ Email _____

Address _____ City _____ Home Phone _____

_____ State _____  Mobile Phone _____

Zip _____ Work Phone _____

 Preferred phone for **voice** calls Home Mobile Work

Preferred contact method for automated appointment reminders (select one or more)
 Voice (preferred phone selected above )
 Text (enter mobile phone above )
 Email (enter email address above)
 Do Not Remind Me

Patient Portal Access (please select one):

Please email an invitation to the patient portal (email address above) I decline access to the patient portal

Referred By _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

Primary Care Physician _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

List other physicians you are currently seeing _____

Are you currently residing in a skilled nursing facility? Yes No If yes, name of facility _____

Notify in case of emergency:

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip+4

Pharmacy _____ Phone _____

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)

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

If yes, which one? _____

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/injury? Yes No Date of illness/injury _____ Date last worked _____

Cause of accident, if any _____

I hereby authorize release of my medical records from _____ to Texas Pulmonary & Critical Care Consultants, PA. This authorization expires upon written notice from patient/patient representative.

Signature of Patient or Responsible Party

Date

FINANCIAL POLICY

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

Responsible Party Name _____ Phone _____ Relationship _____
Address _____
Street City State Zip+4

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. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. We are not responsible for misinformation given by your insurance company. You will be refunded any over-payments or billed for any balance after the claim processes.

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.

Appeals – You appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as your authorized representative in requesting an appeal from your insurance plan in the event of denial of services/denial of payment. You agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to Texas Pulmonary/Sleep Consultants, and you direct the plan to do so in that event.

Out of Network Billing – The physicians may not be participating providers with your insurance plan and, if not, benefits may be reduced and/or your portion may be applied to your out-of-network deductible.

Signature of Patient or Responsible Party

Date

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.

Signature of Patient or Personal Representative

Date

A copy of our Notice of Privacy Practices will be provided at your request.

Texas Pulmonary & Critical Care Consultants, PA

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Texas Pulmonary & Critical Care Consultants, PA, must have my consent, therefore I authorize Texas Pulmonary & Critical Care Consultants, PA to disclose my PHI as described in the provided forms to the recipients listed below:

Description of the information to be disclosed (check all that apply):

All Procedures Test Results Appointments Other Surgeries Billing/Account information

Name(s) of the person(s) authorized to obtain the above-mentioned information (e.g. family members and other specified person(s), physician other than your referring doctor).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Contact Information:

I authorize Texas Pulmonary & Critical Care Consultants, PA to contact me at the following number with results or questions:

Home _____ Cell _____ Work _____

May we leave a detailed message on your answering machine or voicemail?

Yes No Failure to check one of these boxes may delay results

By Patient: (printed name) _____ DOB: _____

Patient Signature: _____ Date: _____

Or Patient's Representative (print name, sign and describe authority)

_____ Date: _____

By signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. You understand that your records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that you have the right to revoke this authorization at any time, provided you do so in writing; that you have been given the opportunity to ask questions; that you have received a copy of the signed authorization; that you may inspect a copy of your PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to you or your treatment upon receipt of this signed authorization; and that you may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.



2941 OAK PARK CIRCLE, SUITE 200 • FORT WORTH, TEXAS 76109
(817) 332-7433 • FAX (817) 394-6282

1201 FAIRMOUNT AVENUE • FORT WORTH, TEXAS 76104
(817) 335-5288 • FAX (817) 338-0927

6100 HARRIS PKWY, STE. 285 • FORT WORTH, TEXAS 76132
(817) 263-5864 • FAX (817) 263-3791

*Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research*

Sleep Laboratory – 2941 Oak Park Circle, Ste. 200, Fort Worth, TX 76109
Email: Information@SleepConsultants.com
Internet: <http://www.SleepConsultants.com>

Advanced Practice Provider Consent

This facility has on staff advanced practice providers to assist in the delivery of pulmonary care.

These advanced practice providers are not physicians. They have received advanced education and training in the provision of health care. Each can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above and hereby consent to the services of an advanced practice provider for my health care needs.

I understand that at any time I can refuse to see the advanced practice provider and request to see a physician.

Name

Date

Signature