SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Murfreesboro 1508 Carl Adams Drive Ste 200, Murfreesboro, TN 37129 (615) 893-4896
Murfreesboro Medical Clinic 1272 Garrison Drive, Ste 301, Murfreesboro, TN 37129 (615) 893-4896
Cool Springs 3326 Aspen Grove Dr, Ste 260, Franklin, TN 37067 (615) 893-4896
Clarksville 1750 Memorial Drive, Clarksville, TN 37043 (931) 614-6324

PATIENT Name ____

Birthdate ____________________ Social Security Number ____________________ Sex: M F

Address ___________________________ City __________________ St _____ Zip ________

Home Phone __________________Cell Phone __________________ **Marital Status:** M S D W

E-mail address: ____

Language: English, Russian, Spanish, Indian (includes Hindi & Tamil), or Other.

Race: American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, White, Hispanic, Other Race, Other Pacific Islander, Unreported/Refused to Report

Ethnicity: Hispanic or Latino ___ Yes ___No ___ Refused to Report

Referred by: __________________ **Primary Care Doctor:** ____________________________

Pharmacy: __________________ **Pharmacy Address:** ____________________________

PRIMARY INSURANCE __________________________ **Policy/ID** ____________________

Name (IF OTHER THAN PATIENT) ____________________________ Birthdate ____________

SECONDARY INSURANCE ________________________ **Policy/ID** ____________________

Name (IF OTHER THAN PATIENT) __________________________ Birthdate __________

EMERGENCY CONTACT: Name __________________ Phone _________ Relationship _________

APPOINTMENT REMINDERS
How would you like to be contacted regarding your upcoming appointments? (check all that apply)

____ Home Phone ____ Cell Phone ____ E-mail ____Text Message

ELECTRONIC MEDICAL RECORDS ONLINE ACCESS
SCMT has the ability to provide access to your Electronic Medical Record to you via HIPAA compliant website.

Would you like access to your Electronic Medical Record online? ____ Yes ____ No

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM
I have received a copy of Sleep Centers of Middle Tennessee, PLLC's Notice of Privacy Practices.

Signature: ______________________________________ Date: ________________

RELEASE: I, the above named patient, authorize Sleep Centers of Middle Tennessee, PLLC or any of its agents, to release any and all of my medical information and appointment information to the following individuals who are involved in my treatment:

Name ____________________________________ Relationship ____________________

Name ____________________________________ Relationship ____________________

Signature ____ Date ___________

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BY SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Patient Name_____________________________________ Date of Birth _______________________________

I hereby authorize the internal use or disclosure of any and all of my protected health information by Sleep Centers of Middle Tennessee, PLLC (the "Practice") for marketing and advertising purposes, including but not limited to targeted advertisements and promotions of products that the Practice believes may be useful or desirable to me.

I understand that this authorization is voluntary and that I may refuse to sign it.

I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization, if any, may be found in my provider's Notice of Privacy Practices.

I understand that, if my information is used by or disclosed to a third-party that is not a health care provider or a health plan, the information used or disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study.

This authorization will expire if and when I end my provider-patient relationship with the Practice.

____ ______________________

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:____

FINANCIAL POLICY

I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to Sleep Centers of Middle Tennessee. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

Signature: ____ Date: _____________________

We are happy that you have chosen Sleep Centers of Middle Tennessee to provide your healthcare needs. We are committed to providing the best care and service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be glad to answer any questions you may have.

We participate in most insurance plans, but due to continuing changes within the insurance industry, we cannot guarantee that your services will be covered. However, we will work with you and your insurance company to come to an agreement if we are not contracted with your carrier. As most insurance companies do not require pre-certification for our services, it is the patient's responsibility to check to see if predetermination is required. Our staff will provide pertinent information upon request.

We will file all claims to the patient's insurance company(s) upon receipt of all required information and releases. You will not be sent a statement until after we have received payment or denial from the insurance. All statements are due and payable upon receipt. Insurance payment authorizations are included in your paperwork. Should you refuse to sign the authorization to have your insurance benefits paid to us, you will be responsible for paying the total of your charges at the time of service. It is the patient's responsibility to ensure that Sleep Centers of Middle Tennessee is a contracted provider for his/her insurance.

________ initials — I understand that the contract between me and the insurance company provides that all co-payments are due and payable at the time of service and that service can be denied if I am not prepared to pay my co-pay per the contract between my insurance company and the provider. (discretion on a case by case basis)

________ initials — Advance notification of at least one business day is required to cancel or reschedule an appointment. Missing an appointment without appropriate notification may result in a $25.00 fee.

Unless prior arrangements have been made, those who are uninsured are expected to pay at the time of the service. We accept MasterCard and Visa for your convenience. I have read, understand, and agree to abide by the above policies.

Printed Name____ Date of Birth_______________________

Signature ____ Date______________________________

EPWORTH SLEEPINESS SCALE

Name: ____________________________ Date: __________________

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing
1) Sitting and reading?	____________
2) Watching TV?	____________
3) Sitting inactive in a public place (e.g., theater, meeting)?	____________
4) As a passenger in a car for an hour without a break?	____________
5) Lying down to rest in the afternoon when circumstances permit?	____________
6) Sitting and talking to someone?	____________
7) Sitting quietly after a lunch without alcohol?	____________
8) In a car, while stopped in traffic for a few minutes?	____________
SCORE:	____________

Questions © M. W. Johns 1990-1997

MEDICATION (NAMES ONLY)		

PAST MEDICAL HISTORY		

ALLERGIES		

PAST SURGICAL HISTORY		

FAMILY HISTORY				
MOTHER		FATHER		OTHER

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
BY SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Patient Name______________________________ Date of Birth ______________________________

Person or Organization Receiving the Information:

Name Address City, State, Zip

1. ____

2. ____

Specific Description of the Information to be disclosed:

- ☐ All Medical Records
- ☐ Other (Specify):____

The Purpose of this disclosure is:____

This authorization will expire on: Date: NONE OR when the following occurs: ______________________________

(Note: If no expiration is indicated above, this authorization will expire one year from the date of signing, as written below.)

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization, if any, may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

____ ______________________

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:____