



Welcome and Thank you for choosing Tri Valley Sleep Center!

Attached you will find our Registration and Patient Forms ***. Please follow the instructions and complete the forms in the attached package.

After you have filled in the forms, please choose one of the options below (in order of preference) for sending us your paperwork, which will make the process more efficient and avoid delays during your appointment:

1. You can press the **EMAIL** button below and it will email this completed package to our office directly. [This is preferred], Please save or print a copy of this package for your records. If you have difficulty using the EMAIL button below, you can save this package and email it directly to office@trivalleysleep.com
2. You can print this package by pressing the **PRINT** button below and sign it and bring it to your appointment.
3. You can print and **FAX** this package to (925) 327-0300.

We request you are present 15 minutes prior to your appointment time for check-in. Please bring your Driver's License and Insurance Card with you.

We are located at 5201 Norris Canyon Road #120, San Ramon, CA 94583. If you have any questions, please visit our website www.trivalleysleep.com or phone us at (925) 327-0200.

We are located across the parking lot from the San Ramon Regional Hospital off of Alcosta and Norris Canyon Road. If you are on the freeway take the Crow Canyon exit to the right, keep right until you reach Alcosta, turn right onto Alcosta, then left onto Norris Canyon Road.

We are always here to help you, if you have any questions, please feel free to contact us at (925) 327-0200 or at office@trivalleysleep.com.

Thank you and we look forward to seeing you.

*** You will need Adobe Acrobat to view and print this package. If you need this free program please go to:

www.get.adobe.com/reader or click:

PATIENT REGISTRATION

Welcome to **Tri Valley Sleep Center, LLC.**
 In order to serve you properly, we will need the following information. **(Please Print)**
 All information will be strictly confidential.

Patient's Name		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Birth Date ____/____/____ Age _____	Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
Residence address		City	State	Zip	Home Phone:
Person financially responsible for this account		Self <input type="checkbox"/> Spouse <input type="checkbox"/>	Responsible Party's Birthdate ____/____/____		Responsible Party's Social Security #
Name of employer: <input type="checkbox"/> Not Applicable or Address:		Business Phone			Occupation
Reason for Visit:		Referred by: (include address and phone)			
Person to contact in case of emergency:			Relationship to patient		Phone
Medicare Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicare #		Medicaid Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicaid #	
Medicare Secondary insurance name			Address		Effective Date
Medicare Secondary insurance name			Address		Policy #
Primary insurance company			Address		Group #
Primary insurance company			Address		Is insurance through your employer?
Subscriber Name		Subscriber birth date		Policy #	
Subscriber Name		Subscriber birth date		Policy #	
Secondary insurance name			Address		Group #
Secondary insurance name			Address		Policy #
Secondary insurance name			Address		Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to **Tri Valley Sleep Center, LLC.** for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge and fully understand that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures I have been given the opportunity to ask questions regarding my diagnosis, treatment, the procedures used, and alternatives available, if any.

I have received a copy of my Patient Rights and Responsibilities, this facility's Grievance Procedure, and have been offered information regarding Advance Directives.

 Patient, Parent or Guardian Signature (if child is under 18 years old)

 Date

Tri Valley Sleep Center, LLC.
INITIAL QUESTIONNAIRE
Page 1 of 2

DATE _____

Last Name _____ First Name _____ MI _____

Address _____

Phone number _____ Work No. and Cell No _____ Birth Date _____ SS #: _____

Primary Care Physician _____

Who referred you to **Tri-Valley Sleep Center** ? _____

Medication allergies (please list) _____

Medications: Please list the medications you are now taking:

SLEEP HISTORY

_____ **Height** _____ **Weight**

What time do you usually go to bed? _____ a.m. p.m. _____ p.m. a.m.

What time do you usually get up? _____ a.m. p.m. _____ p.m. a.m.

Do you take naps? (YES) (NO) What time? _____ How long? _____

How long have you had a sleep problem? _____ weeks/months/years

How many nights per week do you have a sleep problem? _____

Do you waken during the night with the sensation of choking? _____ Gasping for breath? _____

Do you wake up in the morning with a dry mouth? _____ With a sore throat? _____

On the average, how often do you wake up during the night? _____

How many times in the night do you get up to urinate? _____

Has there been any loss of short term memory? (YES) (NO) Long term memory? (YES) (NO)

Do you dream? (YES) (NO) Are you bothered by nightmares? (YES) (NO)

Do you have breathing problems at night? (YES) (NO) If yes, describe _____

Tri Valley Sleep Center, LLC.

INITIAL QUESTIONNAIRE

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Has anyone who has observed your sleeping commented on you having pauses in your breathing? _____

Have you been told that your legs jerk repeatedly while you are asleep? (YES) (NO)

Do you ever have an uncomfortable feeling in your legs at bedtime that is relieved only by moving your legs? (YES) (NO)

Do you have sleepy spells during the day? (YES) (NO)

Have you ever had a motor vehicle accident or near-accident because of sleepiness? (YES) (NO)

Do you find it difficult to fall asleep at night? (YES) (NO)

Do you wake up in the night and then find it difficult to fall asleep again? (YES) (NO)

Are you bothered by waking too early and not being able to get back to sleep? (YES) (NO)

On the average, how long are you awake in the morning before you finally get up? _____ minutes

On the average, how long do you actually sleep during the night? _____ hours

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

2 = moderate chance of dozing

1 = slight chance of dozing

3 = great chance of dozing

SITUATION

Sitting and reading _____

Watching television _____

Sitting inactive in a public place (theater or meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

Tri Valley Sleep Center, LLC.

Date: 4/1/2013

RE: Cancellation and Reschedule Policy

EFFECTIVE IMMEDIATELY

As of April 1, 2008, all study patients scheduled or to be scheduled will be subject to this updated cancellation and rescheduling policy.

All cancellations and reschedules done within 72 hours of the scheduled study will be subject to a \$75.00 fee.

All cancellations and reschedules done within 48 hours of the scheduled study will be subject to a \$150.00 fee.

If a cancellation or reschedule is not done and the patient is a no-show to the scheduled test, a fee of \$200.00 will be assessed.

These amounts will not be billed to any third party or private insurance and will be the sole responsibility of the patient scheduled to be tested. Last minute reschedules and no-shows have a large financial impact to the center as it is difficult to fill a spot for a test in less than 72 hours, thus raising overhead and costs to other patients. This policy will help defer some of those costs, while allowing a continued superior patient experience, and outstanding quality of service and testing.

Thank you for your understanding.

Management

Signature: _____

Date: _____



Payment Agreement

There are times when the insurance carrier may pay the member (you) instead of the Facility for the Dates of Service in which you studied with TVSC. If this is the case with your insurance carrier and they do indeed send you the payment, you are responsible for paying TVSC that exact dollar amount, so that we may credit your account accordingly.

TVSC will be alerted by your Insurance Carrier with an Explanation Of Benefits that states the DATE and AMOUNT you were paid.

The turnaround time for payment back to TVSC is 2 business days from the DATE if which you received the check(s).

Print Name: _____

Signature: _____

Date: _____

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF
INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/disclosed:
MEDICAL RECORDS

OTHER _____
2. The information will be used/disclosed for the following purpose(s):
CONTINUANCE OF CARE

OTHER _____
3. Persons/organizations authorized to use or disclose the information:
Tri Valley Sleep Center, LLC

4. Persons/organizations authorized to receive the information:
REFERRING PHYSICIAN

OTHER _____
5. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to deny that health care.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on this authorization.
8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.
9. This authorization expires on [upon] _____

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient or representative's
authority to act for the patient, if applicable

A copy of this signed form will be provided to the patient.

Summary of Patients' Rights and Responsibilities

We are committed to serving you with compassion, care, skill, and respect. **Tri Valley Sleep Center, LLC.** does not discriminate on the basis of sex, age, creed, race or national origin. As one of our patients, you have choices, rights and responsibilities.

You have the ***RIGHT***:

- to be treated with dignity and respect
- to know the names and professional status of people serving you
- to privacy
- to confidentiality of your records
- to receive accurate information about your health-related concerns
- to know the effectiveness, possible side effects and problems of all forms of treatment
- to participate in choosing a form of treatment
- to receive education and counseling
- to consent to, or refuse, any care or treatment
- to select and/or change your health care provider
- to review your medical records with a clinician
- to file a concern or grievance
- to fair and humane treatment
- to information about services and any related costs
- to self determination; including the right to make choices about life-sustaining treatment

You also have the ***RESPONSIBILITY***:

- to seek medical attention promptly
- to be honest about your medical history
- to ask about anything you do not understand
- to follow health advice and medical instructions
- to report any significant changes in symptoms or failure to improve
- to respect clinic policies
- to keep appointments or cancel in advance
- to seek non-emergency care during regular business hours
- to provide useful feedback about services and policies.

Signature

Date

Tri Valley Sleep Center, LLC.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our facility uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our facility.

How We May Use or Disclose Your Health Information

For Treatment. We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, therapist, nurse, or other person providing health services to you, will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions take by them in the course of your treatment and note how you respond.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by law. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken action in reliance on such.

Your Health Information Rights

You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. §164.522; however, our facility is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- request that your health record be amended as provided in 45 C.F.R. §164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Concerns/Complaints

You may complain to our facility and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Managing Employee or complete and return a Patient Concern Form to our facility.

Our Obligations

Our facility is required by law to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

We reserve the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

Contact Information

If you have any questions or complaints, please contact:

**Clinic Manager
Tri Valley Sleep Center, LLC.**

**ACKNOWLEDGEMENT OF RECEIPT OF
Tri Valley Sleep Center, LLC.
NOTICE OF PRIVACY PRACTICES**

By signing this document, I acknowledge that I have received a copy of **Tri Valley Sleep Center, LLC.** Notice of Privacy Practices.

Name (Print)	Signature	Date
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Tri Valley Sleep Center, LLC. Use Only

Date acknowledgement received: _____

-OR-

Reason acknowledgement was not obtained:

Information Sheet

Your sleep study will be performed at **Tri-Valley Sleep Center**. Our address is 5201 Norris Canyon Road, Suite 120, San Ramon, CA 94583. Telephone: **925-327-0200**. We are located in the medical office buildings adjacent to the San Ramon Regional Hospital.

What to Expect:

The lab is equipped with individual bedrooms. A bathroom is conveniently located outside the bedroom. You will be asked to fill out some paperwork prior to the technologist preparing you for the sleep study. The forms in this packet will be collected at that time.

What to Bring:

1. Bring pajamas, shorts or jogging pants to sleep in. If you prefer to use **your own pillow**, please bring it with you [**WE RECOMMEND IT**]. You may also bring something to read, if you would like.
2. Please bring your own toiletries, i.e., toothpaste, comb, etc.
3. Please bring and take all medications as usual. **Tri-Valley Sleep Center** does not provide any medications, prescribed or non-prescribed. You may want to ask your physician to prescribe a sleep aide to relax you for the study.

ON THE DAY OF THE STUDY, PLEASE DO THE FOLLOWING:

Please do not drink any caffeine or alcohol after lunch.

Prior to your arrival, please bath or shower, and shave. If you have a beard you do not have to shave it off. **DO NOT use any face or body moisturizers, lotions, oils, hair sprays or gel.**

Please bring the following:

1. Your Insurance referral authorization (if required)
2. Your Insurance card for the tech to copy
3. Your co-pay (if applicable)

OTHER INFORMATION:

The test will be completed at approximately 5:30 am. **You will be leaving by 5:45 am. If you are waiting for a ride please ask them to be here by 5:30 am.**

Patients with nutritional needs (diabetic, etc.) should bring necessary snacks.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR STUDY, PLEASE CALL TRI-VALLEY SLEEP CENTER AS SOON AS POSSIBLE BETWEEN THE HOURS OF 9:00 am – 4:00 pm AT: 925-327-0200, [PLEASE BE AWARE OF THE CANCELATION POLICY] (please leave a message if after hours)

We look forward to seeing you at our facility!

POLYSOMNOGRAM (SLEEP STUDY) INSTRUCTIONS

PATIENT : _____ DATE/TIME: _____

You are scheduled for an all night sleep study. **It is important that you arrive at your scheduled time** as there may be other patient(s) scheduled on the same night of study.

PLEASE BRING:

- Your bedtime clothes and change of clothes for the next day
- Your toiletries (i.e., toothpaste, toothbrush, etc.)
- Your medicines as prescribed by your doctor. The Sleep Center cannot provide you with medicines. Certain medicines are not to be taken during the study. With the consent of your physician, the medicine(s) may be withheld.
- A comfortable pillow and personal blanket (if you forget, we will provide these for you).

PROCEDURE:

The technician will ask you to change into your bedtime clothes and fill out a bedtime questionnaire. S/He will then mark and measure your head so as to apply the proper placements of the EEG (brain wave) electrodes. None of the monitoring devices will hurt. None of the devices will cause or induce pain. We will be monitoring the following parameters:

- ⦿ EEG (Electroencephalograph or brain waves) to monitor what stage of sleep you are in.
- ⦿ EOG (Electro-oculograph or eye waves) to monitor your eye movements
- ⦿ EMG (Electro-myograph or muscle activity) to monitor your limb movements and chin activity
- ⦿ ECG (Electro-cardiograph or heart rate) to monitor your heart beat and rhythm
- ⦿ Respirations from your nose and mouth as well as from your chest and abdomen. Your nose and mouth will be monitored by either a nasal pressure monitor or thermocouple which looks like an oxygen cannula. Your chest and abdominal respiratory efforts will be monitored by belts which are placed around your abdomen and chest. These are placed outside your bedtime clothes.
- ⦿ Oximetry will be monitored by a finger probe, which will read your oxygen saturation levels throughout the night.

The entire hook-up procedure takes approximately 45-60 minutes. We typically would start the sleep study between 10-11:00 pm. You are free to walk about the Sleep Center after being hooked-up. During the night you are free to use the restroom on your own. You are also allowed to sleep in any position during the night, although we would like to see some time on your back. If you have a medical condition that prevents you from sleeping on your back, please let the technician on duty know. Do not be afraid to sleep in any position. The monitoring devices are very sturdy. If a monitoring device gets pulled off, the technician will fix it. In the morning, the technician will remove all of the monitoring devices. This process takes about 15-20 minutes. Afterwards, you are free to wash up. The study usually ends between 5:15-5:30 am.

PLEASE NOTE: You are to eat dinner prior to coming to the Center. If you require special assistance in getting in and out of bed, you must bring an aide to be responsible for this care. Please take a shower and wash your hair prior to coming to our Center. Removal of all make-up, perfume/cologne prior to coming to Center is recommended. **If, for some reason, you cannot keep this appointment, you must notify us per the Cancellation and Reschedule Policy otherwise you may be assessed up to a \$200.00 cancellation fee.** Please leave all valuables at home when scheduled for your sleep study.

DO NOT CONSUME ANY CAFFEINATED OR ALCOHOLIC BEVERAGES AFTER 12:00 PM THE DAY OF YOUR STUDY!

Directions to 5201 Norris Canyon Rd., Suite 120

San Ramon, CA 94583

925-327-0200

From Walnut Creek:

- 680 South
- Exit Crow Canyon
- Turn left on Crow Canyon.
- Turn right on Alcosta Blvd.
- Turn left on Norris Canyon Rd. (take first right up the hill towards the hospital)
- Take the first left at the white sign “Physician’s Offices”
- Our building is the first one on the left, #5201, Suite 120.
- Please park on the west side of the building by the wheel chair ramp. Walk up the ramp to the back door where you will see the Tri Valley Sleep Center doorbell. Ring the bell and the tech will let you in the building.
- After Hours phone # if needed: 925-327-0237

From Stockton:

- 580 West to 680 North
- Exit Crow canyon
- Turn right on Crow Canyon
- Turn right on Alcosta Blvd.
- Turn left on Norris Canyon Rd (take first right up the hill towards the hospital)
- Take the first left at the white sign “Physician’s Offices”.
- Our building is the first one on the left, #5201, Suite 120.
- Please park on the west side of the building by the wheelchair ramp. Walk up the ramp to the back door where you will see the Tri Valley Sleep Center doorbell. Ring the bell and the tech will let you in the building.
- After Hours phone number if needed: 925-327-0237

From Pleasanton:

- 680 North
- Exit Crow Canyon and follow above directions from there.

Patient Satisfaction Survey

Dear Patient:

Thank you for choosing **Tri Valley Sleep Center**

for your sleep study. Your opinion of our service is very important to us. We are committed to providing the highest quality service to you, our patient. Your suggestions help us improve our services and fulfill our goal in offering the best possible service to you and future patients.

Please indicate the **date** of your Sleep Study: _____

How did you learn about us?

- | | |
|--|---|
| <input type="checkbox"/> Dr. referral/suggestion | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Friend/family | <input type="checkbox"/> Personal Knowledge |
| <input type="checkbox"/> Other | |

Did the technologist introduce him/herself to you and explain the testing procedure(s)? Yes No

Comments: _____

Were you treated in a professional and courteous manner? Yes No

Comments: _____

Did our staff pay special attention to your needs with respect for privacy and dignity? Yes No

Comments: _____

Was the study setting comfortable? (i.e., temperature, noise, etc.) Yes No

Would you recommend our center to a friend or family member? Yes No

Additional Comments:

Thank you for your time!

Please return this form to the front desk before you leave.

If you would like to speak with us about your experience, please call and speak to:

Manager at **925 - 327 -0200**

