5620 W. Thunderbird Rd. Ste B3
Glendale, AZ 85306
P: 602-206-6262
F: 602-235-0296
sonoransleep.com

Registration Form

Patient Information:

Last name:_____ First Name: _____ Middle name/Initial:_____

Date of Birth:_____ Age:_____ Sex:_____ Social Security Number:_____

Address: _____ City: _____State: _____ Zip code: _____

Ethnicity: _____ Race: _____ Language: _____

Parent/Guardian First and Last name: _____ Relationship: _____

Cell phone:_____ Home phone: _____☐ same as cell

Email: _____ Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

Emergency contact Name: _____ Phone:_____Relationship:_____

Primary Care Physician: _____ Phone number:_____

Pharmacy Name: _____ Phone number: _____

Address: _____ City: _____State: _____ Zip code: _____

Preferred contact ☐ email ☐ phone ☐ SMS/text message ( )

EMAIL/SMS and/or Patient Portal Opt in Agreement

We may send a voicemails, emails, text messages (SMS) to you with information regarding your office visit with your consent. This information is only to provide quality care and not shared with anyone. Check below if you would like to opt in to set up appointment reminders, medication refills, access medical records and receive medical records through these communication tools. (This does not apply to controlled medications). You may opt out at any time by notifying us in writing.

☐ **Opt in** ☐ **I request to decline any technical forms of communication**

Insurance Information: *(Please include a copy front and back)*

Primary Insurance:_____Primary Insured Name:_____ Date of Birth:_____

ID number:_____Group number:_____ Relationship to patient: ☐ self ☐ spouse ☐ other

Insurance Address: _____ City:_____ State:_____ Zip code:_____

Secondary Insurance:_____Insured Name:_____ Date of Birth:_____

ID number:_____Group number:_____ Relationship to patient: ☐ self ☐ spouse ☐ other

Insurance Address: _____ City:_____ State:_____ Zip code:_____

Responsible Party/Guarantor:

☐Parent ☐ guardian ☐ caregiver

Name of Party: _____Relationship: _____ Date of Birth:_____

Address: _____ City: _____State: _____ Zip code: _____

Prescription Refills:

If a refill is required prior to scheduled office visit, refill requests will be handled within 24 hours, unless there is a problem and we will notify you otherwise. Do not wait until you are out of medication before calling your pharmacy for a refill. **Any request for refill made on Friday afternoon will not be made until Monday morning.** Refill requests must be made during office hours. **Refill requests will not be authorized at night or during weekends.**

Notice of Privacy Practices

The office of Sarah Patel MD PC dba Sonoran Sleep Center is dedicated to protect your "non public personal health information", This notice is to tell you how and why we collect that information, who has access to that information, and your rights regard that information. Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This ensures that the information we collect is correct. We may also ask a doctor or other health care provider who referred you to this practice to give us health information for evaluation and treatment purposes. This benefits you in that we will have prior medical history that has already been obtained by the referring entity. We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance. To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those-entities that need your information to process health care claims and obtain payment for our services have access to your personal health information (PHI). Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your PHI. These entitles are mandated by Law and this practice has no jurisdiction over such entities. Our practice will obtain your written authorization for uses and disclosures that are not covered by this Notice of Privacy Practices or permitted by applicable law, such as for research or marketing. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

We release your information only to those entities who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entitles who need this information for claims processing have access to your PHI. You have the right to inspect your PHI and have the right to amend any errors you may find in your record. if you leave this practice, your PHI will continue to receive the protection outlined in this notice. If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services; Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C., 20201, or phone (202) 619-0257 or toll free (877) 696-6775. All complaints submitted to the practice must be submitted in writing. You will not be penalized for filing a complaint.. This practice reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office and our website. This notice is effective as of January 20, 2020. Notice of Privacy Practice is also available at our website: sonoransleep.com. You are entitled to receive a paper copy of this Notice of Privacy Practices at any time. If you have any questions regarding this Notice of Privacy Practice or the health information privacy policies of this practice, or to obtain a paper copy of this Notice of Privacy Practice, please call us at: (602) 206-6262.

If you intend to request any information regarding your PHI or exercise any rights under this Notice of Privacy Practice, please notify us in writing at: Sonoran Sleep Center, 5620 W Thunderbird Road Ste B3, Glendale, AZ 85306.

I acknowledge that this practice's Notice of Privacy Practice has been made available to me.

Parent/Responsibility party signature: _____ Date: _____

Patient Financial Responsibility Form

The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care. Your insurance is a contract between you and your insurance company. We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your coverage. This includes all primary, secondary and any tertiary coverage. Patient (or patient's guardian) is responsible for payments of co pays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan. Co-pays are due at the time of service. Coinsurance and deductibles are due at the time of service. This charge is an estimate of what your insurance carrier covers. Patients may incur, and are responsible for payment of any additional charges, if applicable. This includes any charges that are not covered by any secondary or tertiary insurance. We expect and encourage you to know your insurance benefits, including but not limited to co payments, coinsurance, deductibles and services that are covered or not covered by your carrier. All out of pocket amounts quoted by Sonoran Sleep Center are estimates. Prior approvals that are received from your insurance company are not a guarantee of payment. The patient (or patient's guardian) is required to provide a copy of your insurance card(s) and photo ID at the time of visit. Additionally, a credit/debit card may be required to be kept on file for guarantee of payment(s) or cancellation fees. A cancellation/no show fee of $50.00 will be charged if you do not notify us at least 24 hours prior to your scheduled consultation or office visit appointment. You must notify us at least 48 hours prior to your scheduled Sleep Study or there will be a $200.00 cancellation fee. The notification must be business days which are Monday through Friday. Please contact us at (602) 206-6262. Patient statements are mailed monthly.

Payments for invoices that are billed to the patient are due 30 days from receipt of billing. A $25.00 fee will apply if payments are late. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement. A service charge will apply for any payment arrangements.

You are responsible for additional charges for the following copying and distribution of patient medical records: $25.00; forms completion, including but not limited to FMLA forms $25.00. Please allow 10 business days to complete these forms.

Patients who are not covered by health insurance are required to pay for the provided services at the time of service. You may also choose to pay directly for health care services, and if you choose to do you, we will not submit a claim to your insurance company. It is your responsibility for notifying us when you do not wish a claim to be submitted on your behalf.

I, the undersigned, certify that I or my dependent have insurance coverage as indicated above. I assign directly to Sonoran Sleep Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the practice to release all medical and other necessary to insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care including for securing the payment of benefits. I authorize the use of this signature on all insurance submissions.

I acknowledge that this practice's patient financial responsibility form has been made available to me.

Parent/Responsibility party signature: _____ Date: _____

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Telemedicine Patient Consent Form

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to Sonoran Sleep Center providing health care services to me via telemedicine.

All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician. Telemedicine visits may not be available for all conditions, and it is also possible that during or after a telemedicine visit, we may ask you to come to our practice for a face-to-face visit with a clinician if we need to perform certain physical exams that reaches beyond the abilities of telemedicine technologies.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I may revoke my consent in writing at any time by contacting Sonoran Sleep Center. As long as this consent is in force (has not been revoked) Sonoran Sleep Center may provider health care services to me via telemedicine without the need for me to sign another consent form.

Signature of parent/guardian: _____ Today's Date: _____

Consent for Medical Treatment

I hereby give consent for medical treatment of my children who are minors (Please list all children):

_____

_____

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

Consent to Bring Minor for Evaluation/Treatment

I am giving permission for the following adults to bring my child for treatment:

_____

_____

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

The person brining the minor to the appointment must provide a valid photo I.D.

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SLEEP MEDICINE NEW PEDIATRIC PATIENT QUESTIONNAIRE

Patient's Name: _____

Parent/Guardian: _____ Pediatrician/Referring Physician: _____

What problem causes your child to seek our help?_____

CHECK the box for each problem your child **CURRENTLY HAS:**

- ☐ Snoring
- ☐ heavy or loud breathing at night
- ☐ Wake up choking/snorting/gasping for breath at night
- ☐ Witnessed Apnea (breathing pauses at night)
- ☐ Frequent awakenings at night
- ☐ Awaken un-refreshed
- ☐ Teeth grinding during sleep
- ☐ Sweating a lot at night
- ☐ Morning dry mouth
- ☐ Morning headaches
- ☐ Waking up with sore throat
- ☐ Restlessness/discomfort in legs when trying to fall asleep
- ☐ Restless sleep or moves often during sleep
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep at night
- ☐ Sleeps in parents bed
- ☐ Struggle at bedtime (cries or refuses to stay in bed)
- ☐ Sleep talking
- ☐ Nightmares
- ☐ Sleepwalking
- ☐ Sleep terrors
- ☐ Tongue biting in sleep
- ☐ Bedwetting
- ☐ Acting out dreams
- ☐ Feeling paralyzed when falling asleep or waking up
- ☐ Hallucinations when falling asleep or waking up
- ☐ Sudden muscle weakness when laughing
- ☐ Sudden muscle weakness when afraid
- ☐ Uncontrollable daytime sleep attacks
- ☐ Falling asleep unexpectedly
- ☐ Falling asleep at school
- ☐ Recent change in sleep schedule
- ☐ child wake themself up in the morning
- ☐ child wake up groggy
- ☐ Child tired/drowsy in the morning
- ☐ Child hyperactive or irritable during the day at school and home
- ☐ Teacher or supervisor report your child appears sleepy during the day
- ☐ child fidget with hands or feet, or squirm in seat

Medical History- please list or check the boxes:

☐ Seasonal Allergies	☐ ADHD	☐ Sinus Problems	☐ Concussion	☐ Anemia	☐ Urinary Tract Infections
☐ Post Nasal Drip	☐ Sleep apnea	☐ Frequent Ear Infections	☐ Head Injury/ Trauma	☐ Blood Disorder	☐ Depression
☐ Tonsillectomy/ Adenoidectomy	☐ Asthma	☐ Frequent Strep Throat Infections	☐ Seizure Disorder	☐ Leukemia	☐ Anxiety/Panic Attacks
☐ Sinus Problems	☐ Headaches	☐ Spinal Cord Injury	☐ Pneumonia	☐ Childhood Obesity	☐ Bipolar Disorder
☐ Fainting Spells	☐ Speech Difficulty	☐ Thyroid Disease	☐ Poor or Delayed Growth	☐ Genetic Disorder	☐ Trisomy 21 Syndrome
☐ Congenital Heart Disorder	☐ High Blood Pressure	☐ Other:			

Medications:

Name of drug, Vitamin, or herbal supplement	Dose	Number of pills per day	Taken for what Problem? (If known)

Typical Sleep Habits:

1. What time does your child typically go to bed on **WEEKDAYS**? ____:____am/pm
   a. How long does it take your child to fall asleep? _____mins
2. What time does your child typically awaken on weekdays? ____:____am/pm
   a. Groggy or drowsy in the AM? ☐ yes ☐ no
3. How many times does your child awaken on a typical night? _____
4. Does your child have difficulty returning back to sleep? ☐ yes ☐ no
5. What time does your child typically go to bed on **WEEKENDS/DAYS OFF**? ____:____am/pm
   a. How long does it take your child to fall asleep? _____mins
6. What time does your child awaken on weekends/Days off: ____:____am/pm
   a. Groggy or drowsy in the AM? ☐ yes ☐ no
7. Check typical causes for awakening at night:
   ☐ Snoring ☐ Choking/gasping for air ☐ Full Bladder ☐ Bedroom noise ☐ Headache
   ☐ Nightmares ☐ Worry ☐ Thirst/hunger ☐ Bed partner/kids/pets ☐ Night sweats ☐ Heartburn
   Please list other causes:_____
8. Does your child nap ☐ yes ☐ no
   If yes: How often? _____ times per day?
   What time of the day? _____ How long are your child's naps? _____
   Do you feel refreshed upon awakening? ☐ yes ☐ no

Has your child ever had a sleep study before? ☐ yes ☐ no

If yes: Please indicate where and when: _____

Does your currently use a CPAP or BPAP machine at home? ☐ yes ☐ no

Current pressure settings? _____ cm H_{2O}

Please provide the name of your Home Health Company (DME)_____

Relevant Family/Social History:

Child current grade in school: _____ Absences this year: _____ Morning tardies this year: _____

Does your child drink caffeine (including soda)? _____

Does anyone smoke nicotine (including vaping) in the house? ☐ yes ☐ no

Are there guns in house? ☐ yes ☐ no Are the guns locked? ☐ yes ☐ no

Do you have a family history of **any major diseases and or any sleep disorders (obstructive sleep apnea, RLS)**?
If yes, please describe:_____

How **LIKELY** is your child to **DOZE OFF** or **FALL ASLEEP** in the following situations, in contrast to feeling just tired?
Please CIRCLE one number per line:

Never	Rarely	Frequent	Always	
0	1	2	3	Sitting and reading
0	1	2	3	Sitting and Watching TV
0	1	2	3	Sitting, inactive in a public place (example, a theater or a meeting)
0	1	2	3	As a passenger in a car for 30 minutes without a break
0	1	2	3	Lying down to rest in the afternoon
0	1	2	3	Sitting and talking to someone
0	1	2	3	In a classroom at school during the morning
0	1	2	3	Doing homework or taking a test

Sonoran Sleep Center

Pediatric Sleep Log:

Patient's Name: _____ DOB: _____ Today's date: _____

Parent/Guardian: _____

Instructions:
Shade in the boxes when your child was asleep. Use ↓ to mark when child went to bed. Use ↑ to mark time that your child woke up in the morning. In comments indicate any medications given (include dose) and time.

Date	Day	6AM	7AM	8AM	9AM	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM	8PM	9PM	10PM	11PM	12AM	1AM	2AM	3AM	4AM	5AM	6AM	Comments

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