Appt Date:
Appt Time:
Np: *Sleep Med / Neurology*
Copay: $ _____
Amount pd. $_____

Wasatch Sleep Health Center

NEW PATIENT REGISTRATION

Patient Name:
Date Of Birth:
Home Phone:
Social Security #:
Gender:
Marital Status:
Driver's License #:
Patient Address:

Employer Information

Employer:
Work Phone:
Ext:
Position:
Address:

Contact Information

Contact Name:
Phone:
Relationship:
Address:
Date of Birth:
Social Security #:

Primary Care Physician

DR. :
Specialty:
Phone Number:
Address/ Location:

**Do you want us to send your Primary Care Physician, A copy of your Records? Y / N*
** if yes, Before you leave remember to sign a Medical Release Form, Provided by Receptionist.*

* REFERRING PHYSICIAN*

DR. :
Specialty:
Phone Number:
Address/ Location:

Do you want us to send your Primary Care Physician, A copy of your Records?* **Y / N
** If yes, Before you leave remember to sign a Medical Release Form, Provided by Receptionist.*

Wasatch Sleep Health Center
New Patient Registration

**** Do You Carry Health Insurance?**
(If yes, please fill out the boxes marked insurance information).

Insurance Information: **(Primary)**	
Insurance Name:	**Policy #:**
Insurance Plan:	**Guarantor's ID #:**
Insurance Guarantor:	**Claims Address:**
	Member Services Phone #:

Primary Insurance: (Guarantor Information, *If different than the patient)*

Guarantor Name:	**Home Phone:**
Relationship:	**Employer:**
Date of Birth:	**Employer Phone:**
Social Security #:	**Employer Address:**
Home Address:	

****SECONDARY INSURANCE ****

Insurance Name:	**Policy #:**
Insurance Plan:	**Guarantor's ID #:**
Insurance Guarantor:	**Claims Address:**
Member Services Phone #:	

Secondary Insurance: *(Guarantor Information, if different than the patient)*

Guarantor Name:	**Home Phone:**
Relationship:	**Employer:**
Date of Birth:	**Employer Phone:**
Social Security #:	**Employer Address:**
Home Address:	

I request that payment of authorized insurance benefits be made on my behalf to Wasatch Sleep Health Center for any services furnished. I authorize Wasatch Sleep Health Center to release to the insurance company listed above any medical information about me or my dependents which may be needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by insurance. In addition, I am hereby notified that if I do not show for a scheduled appointment, or fail to cancel an appointment, a no show will be noted on my account. I understand that this office holds my medical records in strict confidence. They will not be released to anyone without my explicit written permission. All requests for medical records must be in writing. A reasonable fee may be charged for the compilation of medical records.

_____ _____/_____/_____

Signature of Patient / Guarantor **Signature Date**

Financial Policy – Wasatch Sleep Health Center, Inc.

In accordance with the Federal Truth-in Lending act, all doctors are required to give to their patient complete information in connection with the extension of credit:

a. BASIC POLICY: **The patient is responsible for medical bills in our office.** Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any disputed claims.
b. IF YOU DO NOT HAVE INSURANCE: Our policy requires payment in full today. If you cannot pay in full now, we request partial payment today as you arrange for credit on your account with a payment plan agreement with our Credit and Collection Manager.
c. IF YOU HAVE INSURANCE: Fill out the patient's information form. If you're covered by Medicaid, Medicare or other insurance, please present your identification card to the receptionist at the time of appointment.
d. WORKMAN'S COMPENSATION: In the event it is determined by the Workers Compensation Board that the illness or injury is not the result of a compensable workers compensation case, I hereby agree to pay the usual and customary fees for services rendered.
e. REJECTED CLAIMS: If your insurance company rejects your claim, or if they pay less than the total bill, our policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full after insurance payment, contact our business office.
f. FORMS OF PAYMENT: We can accept payments in cash, check or money order as well as Credit Cards. Please make your check payable to: **Wasatch Sleep Health Center, Inc.**
g. RETURNED CHECKS: a $20 handling charge is applied to all returned checks.
h. DELINQUENT ACCOUNTS: Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the doctor to decide appropriate legal action. We reserve the right to add late charges for delinquent accounts requiring collection action and add attorney fees and court costs.
i. MONTHLY STATEMENTS: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid you are responsible for the unpaid balance.
j. LATE CANCELLATION AND LATE ARRIVAL FEE: Should you need to cancel or change your office visit appointment or arrive late, you will be subject to a $50 charge if you do not do so within 24 hours business day advanced notice. Late arrival is defined as greater than 20 minutes past the appointment time. Should you need to cancel or change an appointment for a procedure or study, you will be subject to $100 charge if the change is not made within two business days advance notice. By signing below, I agree that I'm financially responsible for any charges incurred for missed appointments in which I did not give the required advance notice.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: **Wasatch Sleep Health Center, Inc.**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Your signature authorizes **Wasatch Sleep Health Center, Inc.** to forward medical records to your insurance company, including disability insurance carriers and any physicians necessary to continue your medical care.

If you have any questions regarding this financial policy, please ask or call before you are seen by the doctor.

I HAVE READ AND AGREE TO THE FINANCIAL POLICY OF THIS OFFICE:

Patient: _____ Date: _____

Insured: _____ Witness: _____

Wasatch Sleep Health Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Social Security Number: _____ Patient Phone #: _____

I _____ Authorize: The Wasatch Sleep Health Center To Release My Described Medical Information To The Party Listed Below.

Name: _____

Address: _____

Phone #: _____ Fax # _____

Other Information: _____.

I _____Authorize The Party Listed Below To Release My Described Medical Information To: The Wasatch Sleep Health Center.

Name: _____

Address: _____

Phone #: _____ Fax # _____

Other Information: _____.

(COPIES OF RECORDS REQUESTED - PLEASE CHECK ALL THAT APPLY)

___ Physician's Orders / Progress Notes
___ Sleep Study / Polysomnography Tests
___ Pathology Reports
___ X-Ray Reports
___ Outpatient Surgery
___ Other: _____.
___ Emergency Record
___ History & Physical
___ Discharge Summary
___ Operative Report

Records To Be Released Covering Period Of _____ to _____.

I authorize Wasatch Sleep Health Center to release information to the above named. Wasatch Sleep Health Center is hereby released from all legal liability that may arise from the Release of the Requested Medical Information.

I understand that my records are protected and cannot be disclosed without my written permission. Any re-disclosure of information obtained by this authorization is prohibited except with the written consent of the patient or the legal representative.

_____ ____/_____/_____

Patient Signature / Guardian **Signature Date**

PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE: ____/____/____

Age: _____ R / L Handed Height _____ Weight_____
Do you work outside of the home? Yes / No
What is your occupation? _____
Do you smoke? Yes / No If yes, how many packs per day? _____
Do you drink alcohol? Yes / No How much? _____ How often? _____
Any illicit drug use? Yes / No How often? _____
If So, What Drugs? _____.
List all **ALLERGIES** to medications: _____
What is your most bothersome symptom: _____
When did symptoms begin (approximately) _____
Who was your referring physician: _____
What are the referring physician's main concerns: _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? **(Please check all that apply)**

CARDIAC: (HEART)

___Carotid Artery Stenosis
___Congestive Heart Failure
___Coronary Artery Disease
___Deep Venous Thrombosis
___Hyperlipidemia
___Hypertension
___Myocardial Infarction
___Peripheral Vascular Disease
___ Superficial Phlebitis
___ Superficial Venous Thrombosis
___ Other_____.

PULMONARY: (LUNGS)

___Asthma
___Chronic Bronchitis
___COPD
___Croup
___Cystic Fibrosis
___Pneumonia
___Pulmonary Embolism
___Pulmonary Hypertension
___Sarcoidosis
___Sleep Apnea
___Tuberculosis
___ other _____.

GASTROINTESTINAL: (GALLSTONES)

___Cholelithiasis
___Cirrhosis
___Colonic Polyps
___Crohn's Disease
___ Gastro esophageal Reflux Disease
___ Hepatitis
___ Irritable Bowel syndrome
___ Pancreatitis
___Other _____.

RENAL: (KIDNEY)

___Acute Renal Failure
___Benign Prostatic Hypertrophy
___Chronic Renal Failure
___Endometriosis
___Erectile Dysfunction
___ Infertility
___ Polycystic Kidney Disease
___ Renal Stones
___ Risky Sexual Behavior
___ Urinary Incontinence
___Urinary Tract Infect. Recurrent
___Other _____.

MUSCULOSKELETAL:

___Chronic Pain
___Fibromyalgia
___Fracture(s)
___Gout
___Osteoarthritis
___Osteoporosis
___Polymylagia Rheaumatica
___Rheumatoid Arthritis
___Sjorgren's Disease
___Systemic Lupus Erythematosus
___Other _____.

ENDOCRINE:

___Addison's Disease
___Cushing's Disease
___Type 1 Diabetes
___Type 2 Diabetes
___Hyperthyroidism
___Hypothyroidism
___Other _____.

* Cont' from pg. (1)

NEUROLOGICAL:

___Alzheimer's Disease
___Attention Deficit Hyperactivity Dis.
___Autism
___Cerebral Palsy
___Cerebrovascular Accident
___Dementia
___Disc Disorder with Radiculopathy
___Down Syndrome
___Migraine Headaches
___Tension Headaches
___Huntington's Disease
___Meningitis
___Mental Retardation
___Multiple Sclerosis
___ Muscular Dystrophy
___ Myasthenia Gravis
___ Parkinson's disease
___ Peripheral Sensory Neurop.
___ Seizure Disorder_____.
___ Transient Ischemic Attack
___ other _____.

HEMATOLOGIC: (BLOOD)

___Hemolytic Anemia
___ Iron Deficiency Anemia
___Pernicious Anemia
___Sickle Cell
___Thallasemia
___Other _____.

IMMUNOLOGIC: (IMMUNE SYSTEM)

___Allergies
___Chicken Pox
___Eczema
___Immunodeficiency
___Giardiasis
___Immunodeficiency
___Otitis Media, Frequent
___Psoriasis
___Frequent Sinusitis
___Other

CANCER:

___Bone Cancer
___Brain Tumor
___Colon Cancer
___Hepatic Carcinoma
___Leukemia
___Lung Cancer
___Lymphoma
___Melanoma
___Pancreatic Cancer
___Prostate Cancer
___Renal Carcinoma
___Skin Cancer
___Testicular Cancer
___Thyroid Cancer
___Other

Family History

** Please list any of the above diseases known to be prevalent in your family.*

_____

_____

* Have you had any other chronic diseases?

If yes, please list them: _____.

Surgery

* Have you had prior or upcoming surgeries?

If yes, please list them: _____.

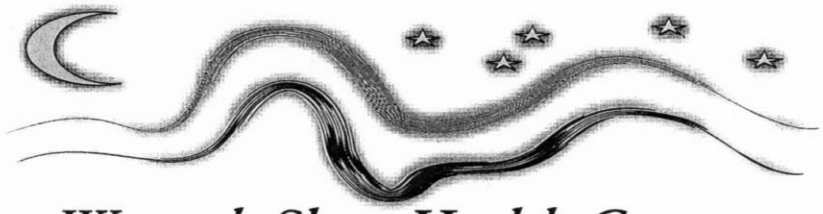
HAVE YOU HAD ANY OF THE FOLLOWING TESTS? (Please check all that apply)

CT scan of the Head	_____yes ____no	when_____	where_____	results_____
MRI of the Head	_____yes ____no	when_____	where_____	results_____
EEG	_____yes ____no	when_____	where_____	results_____
Sleep Study	_____yes ____no	when_____	where_____	results_____
Abnormal lab test	_____yes ____no	when_____	where_____	results_____

LIST ALL MEDICATIONS YOU ARE NOW TAKING – (include those you buy without a prescription)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

PRIMARY CARE PHYSICIAN? _____Phone: _____



Wasatch Sleep Health Center

ACKNOWLEDGEMENT OF RECEIPT OF WASATCH SLEEP HEALTH CENTER'S NOTICE OF PRIVACY PRACTICES.

By signing this form, I acknowledge that I have received a copy of the Wasatch Sleep Health Center's Notice of Privacy Practices.

_____ _____/_____/_____
Patient's Name Date of Birth

_____
Medical Record Number

_____ _____/_____/_____
Patient Signature / or Representative Today's Date

_____
Name of Personal Representative (if applicable)

If signing as Personal Representative, describe authority to act for patient and submit documentation showing such authority: _____.

_____ _____
Name of Witness Signature of Wasatch Sleep Health Center

_____/_____/_____
Today's Date

TO BE COMPLETEDBY WASATCH SLEEP HEALTH CENTER:

Reason Privacy Notice Acknowledgement Not Obtained

1345 East 3900 South #208
Salt Lake City, UT 84124
Phone (801) 281-1788 • Fax (801) 281-2788