Sleep Lab
Sinai Medical Center Ltd

Pre-registration Form P-10

WAKE UP FULL OF LIFE

Please PRINT and COMPLETE form in full. This form includes eight pages including this page.

A. Patient Information

Patient Name (Last Name, First Name)			Social Security Number - -		Date of Birth (MM/DD/YYYY) / /
Street Address	Apt. Number	City	State	Zip	☐ Male ☐ Female
Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single					
Email Address @ .	☐ Home ( ) -	☐ Cell Phone ( ) -			← Please Check the Preferred Contact Phone Number
Emergency Contact Name:			Relationship to Patient ☐ Friend ☐ Spouse ☐ Child ☐ Other……		
Contact Phone: ( ) -	Note:				

B. Patient's Representative ***(Skip this section if same as patient)***

Name (Last Name, First Name)			Social Security Number - -		Date of Birth (MM/DD/YYYY) / /
Street Address	Apt. Number	City	State	Zip	☐ Male ☐ Female
Relationship to Patient ☐ Spouse ☐ Child ☐ Other……	☐ Home Phone ( ) -	☐ Cell Phone ( ) -			← Please Check the Preferred Contact Phone Number

C. Insurance Information ***(Skip this section if you provided us the actual insurance cards)***

Primary Insurance Policyholder			**Secondary Insurance Policyholder**	
Insurance Plan Name	ID Member		Insurance Plan Name	ID Member
Group Number	Policyholder Name (Last Name, First Name)		Group Number	Policyholder Name (Last Name, First Name)
☐ Male ☐ Female	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other……		☐ Male ☐ Female	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other……

D. Referring Doctor (if applicable)

Name:	City:	Office Phone: ( ) -

E. What is your Pharmacy?

Pharmacy	Location	Phone: ( ) -	Fax: ( ) -

By my signature below, I hereby request and consent to medical treatment and I authorize the release of medical information as outlined in practice of information policy I have been given. I authorize payment directly to the physician or supplier for services rendered and I recognize that I am ultimately responsible for payment for services regardless of insurance coverage or non-coverage.

Please sign, date, and continue to the next pages…

Today's Date / / (MM/DD/YYYY)

Signature of Patient / Personal Representative

STAFF USE ONLY. In reviewing the above information I find it to be current and accurate and I renew my above authorization: (initial and date here) ☐ C ☐ I ☐ E

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OUR SLEEP LAB POLICIES AND PROCUDURES

Please read each policy of our urgent care.

INSURANCE CARDS	Insurance cards are required at every visit. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number please inform the urgent care. If you have not provided our sleep lab with the correct insurance information, you will be responsible for any balance due. We are unable to re-submit insurance claims.
SELF-PAY PATIENTS	If you do not have insurance, your balance is due at time of visit. Our sleep lab accepts cash, check, VISA, MasterCard, Discover and American Express.
BILLING STATEMENTS	Regularly our sleep lab sends out a billing statement to every patient. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement each month even if you and your insurance company are disputing coverage.
LATE FOR APPOINTMENTS	Please try to make every effort to notify our sleep lab if you will be arriving late. If you will be more than 30 minutes late, you may need to call our lab and notify them.
NOT SHOWING FOR YOUR SCHEDULED APPOINTMENT	We ask that to call before 04:00 PM to cancel an appointment. No showing for an appointment could result in a $100.00 fee which is not covered by insurance. Frequent no-shows or cancellations could result in being discharged from the practice.
CHANGE IN PERSONAL INFORMATION	Please call or write to the sleep lab concerning any change of personal information such as your address, phone number, or who we may communicate information to concerning your health information, at your earliest convenience. Not updating personal information can delay communication regarding your health information.
EXCHANGE OF MEDICAL INFORMATION	All request by patients must be signed and in writing by letter, fax or a medical release of information form. Verbal requests are not acceptable. A request is not necessary if the information is shared with a physician we referred you to.
DIAGNOSIS CODES	Our sleep lab cannot recode a sleep lab visit because your insurance does not cover certain visits; this is illegal and considered fraud. It is your responsibility to know what your insurance plan covers. Physicals, shots, and psychiatric care are a few examples of what some insurance companies may not cover. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days.
RESULTS FROM TEST	Our sleep lab will notify you with the results from testing as soon as they become available to us and are reviewed by your doctor. If another physician ordered the tests and copies are sent to us, it is the responsibility of the ordering physician to contact you. Unless otherwise instructed we are unable to give out results the same day a test is performed.

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NOTICE OF PRIVACY PRACTICES

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

This practice creates a medical record of your health information in order to treat you, receive payment for services delivered and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgement that you received this Notice. We are required by federal and state law to maintain the privacy of your medical information Medical information is also called. **"Protected health information"** or **"PHI".** This is a list of some of the types of uses and disclosures of your **PHI** that may occur:

TREATMENT:	We obtain health information, or PHI, about you in order for us and others to treat you We may also send. Your PHI to another physician, facility or Counselor to which we refer you for treatment, care, procedures or testing. We may also use your PHI to contact you to inform you about alternative treatments or other health related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.
PAYMENT:	We use your PHI to obtain payment for the services we render. For example, we send PHI to Medicaid, Medicare or your insurance plan to obtain payment for our services.
HEALTHCARE OPERATIONS:	We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time — to — time, we may use your PHI to contact you to remind you of your appointment
LEGAL REQUIREMENTS	
PUBLIC HEALTH:	We may disclose your PHI to prevent or control disease, injury or disability to report births and deaths, or reactions to medical devices or suspected cases of abuse or neglect.
HEALTH OVERSIGHT ACTIVITIES:	We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may also use your PHI in order to assist others in determining your eligibility for public benefit programs and coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.
JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:	We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.
LAW ENFORCEMENT:	We may use and disclose your PHI in order to comply with requests in pursuant to a court order, warrant, subpoena, summons or a similar process. We may also use it to locate someone who is missing, to identify a crime victim, report a death or criminal activity, or in an emergency.
AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:	We may disclose your PHI to avoid you or someone else getting hurt.
WORK-RELATED INJURIES:	We may use or disclose PHI to an employer if they are conducting a medical workplace surveillance evaluate work related injuries.

continue to the next pages...

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS:	We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.
ARMED FORCES:	We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission or to determine eligibility for benefits.
NATIONAL SECURITY AND INTELLIGENCE:	We may use of disclose PHI to maintain the safety of the President or other protected officials for the conducting of National Intelligence activities.
RESEARCH:	You will need to sign an Authorization Form before we use or disclose PHI for research purposes except in limited situations like if you wanted to participate in a research or clinical study.
FUBDRAISING:	If we Undertake any fundraising activities, we may contact you about the activity itself. We do not engage in marketing activities, and need your permission to do So.
ILLINOIS LAW	
Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status or alcohol and drug abuse treatment, you will be required to sign an Authorization form unless State Law allows us to make the specific type of use or disclosure without it. You have certain rights under Federal and State laws relating to your PHI. Some of these rights are described below:	
RESTRICTIONS:	You have a right to request restrictions on how your PHI is used for treatment purposes, payment and health care operations. We are not required to accommodate your request.
COMMUNICATION:	You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.
INSPECT AND ACCESS:	You have a right to inspect Your health information: This includes billing and medical record information. You may not inspect your record in some cases. If you request to inspect your record and are denied, we will send you a letter informing you of the reason why and explaining your options. You may have a copy of you PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making copies and mailing them to you, if you ask us to "nail them.
AMENDMENTS OF YOUR RECORDS:	If you believe there is an error in your PHI, you have a right to request that we amend them. We are not required to agree with your request to amend.
ACCOUNTING OF DISCLOSURES:	You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, healthcare operations or release made pursuant to your authorization,
COPY OF NOTICE:	You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice in our urgent care.
COMPLAINTS:	If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Medical Records department at 708 923-4660. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC. We are required to abide with the terms of the Notice currently in effect; however, we may change this Notice. If we materially change this Notice, you can obtain a copy by stopping by our sleep lab and picking one up. Changes to the Notice are applicable to the health information we already have.

I, **(Patient or Personal Representative Signature)**  _____ have read and received the notice of privacy practices and the list of sleep lab policy and procedures from Advanced Urgent Care.

Please sign above and continue to the next pages...

STAFF USE ONLY. In reviewing the above information I find it to be current and accurate and I renew my above authorization: (initial and date here) ☐ C ☐ I ☐ E

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First Visit Survey

Thank you for choosing us as your sleep center. Please share with us how Sleep Lab at Sinai Medical Center helped you or your loved one to learn about it.

Patient Name (Last Name, First Name)	Date of Birth (MM/DD/YYYY) / /

How did you learn about sleep lab (check more than one, if applicable)?

❑ Outside Signs ❑ Family / ❑Friend - Who may we thank for referring you to us? Name: …… Phone Number: ( ) - City: ❑ Internet Search ❑ Google ❑ Yelp ❑ Facebook ❑ Other (Please Specify): ……	❑ Workplace ❑ Direct Mail ❑ Flyer ❑ E-mail ❑ News Paper ❑ Billboard ❑ Radio ❑ Television ❑ Magazine- Which one…… ❑Doctor referral ❑ Insurance Website

❑ Other (please specify): ……

Do you have a Primary Care Physician (also known as family doctor)?

❑ Yes ❑ No

Tell us about you?
Gender:

❑ Male ❑ Female

Age Group (Patient or Personal Representative):

❑ 15-17 years old ❑ 18-24 years old ❑ 25-34 years old	❑ 35-44 years old ❑ 45-54 years old ❑ 55-64 years old	❑ 65-74 years old ❑ 75 years or older

Please hand this form back to the staff and make sure you get back your ID card and/or Insurance cards