EL PASO SLEEP CENTER

West
4305 N. Mesa Suite B
El Paso, TX 79912

East
3030 Joe Battle
El Paso,TX 79938

PRE-REGISTRATION INFORMATION

Appt. Time & Date: _____

Last Name: _____ **First Name:** _____ **MI** _____

Gender: M / F

Date of Birth: _____/_____/_____ **Social Security #:** _____

Guarantor Name (if different from patient): _____

Address: _____**City:** _____ **State:** _____

ZIP: _____ **Home #: (____)**_____

Cell #: (____)_____

Referring Physician: _____

PCP: _____

Emergency Contact: _____ **Relationship:** _____

Phone #: (____)_____

How did you hear about EL PASO SLEEP CENTER?

_____

Patient to subscriber relationship: Self Spouse Parent Child

Other: _____

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EPWORTH SCALE

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 recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of each situation:

0 = No Chance of Dozing
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching T.V.	
Sitting inactive in a public place (e.g. movies / theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of consultations / sleep study benefits to Dr. Gonzalo Diaz / El Paso Sleep Center For services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.
Yo, autorizo el pago por consultas o estudios del sueno a el Dr. Gonzalo Diaz / El Paso Sleep Center de su parte ya sea en persona o bajo su supervision. Yo entiendo que yo sere responsible por la porcion que mi aseguranza de salud no tiene cobertura.

AUTHORIZATION TO RELEASE INFORMATION

I, hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
Yo, autorizo a el Dr. _____ propocionar informacion medicas que sean necesarias para mi cuidado de salud o para procesar reclamos de aseguranza.

MEDICARE / MEDICAID

I, certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.
Yo, certifico que toda la informacion que he proporcionado para el pago de mis servicios es veridico. Yo, autorizo proporcionar toda mi documentacion medica. Yo, autorizo el pago departe de mi aseguranza para el pago de mi cuidado.

AUTHORIZATION OF PATIENTS RELEASE OF INFORMATION

During the course of your treatment at the El Paso Sleep Center the doctor may prescribe a CPAP unit for your use at home. If the El Paso Sleep Center is not in the network for your particular insurance, the El Paso Sleep Center will forward your information to a medical equipment company to provide you with any medical equipment that may be necessary.

I authorize El Paso Sleep Center to release patient information to a medical equipment company that would be able to further assist me in regards of receiving the CPAP unit or any other medical supplies.

PLEASE PRINT

Patient Name: _____ Date: _____

Parent / Guardian: _____ Date: _____

Signature: _____ Date: _____

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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.

Law Enforcements

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are acquired to report certain communicable disease to the state's public health department.

Appointment Reminders

Your health information will be used by our staff to send you appointment reminders, leave messages on voice mail and with family members.

Other Uses and Disclosures that Require Your Authorization

Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Patient Name: _____ **Date:** _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on own may not be included.

Patient Signature: _____Date Of Birth: _____

Parent / Guardian: _____

DATE: _____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.