NORTH JERSEY
Therapy & Diagnostics
500 Valley Rd, Ste 101, Wayne, NJ 07470
Tel: (973) 595-7500 Fax: (973) 595-7770

PATIENT REGISTRATION

AUTHORIZATION. ACKNOWLEDGEMENT AND CONSENT

Welcome to our facility. In order to properly serve you, we will need the following information (Please Print.)
All Information will be strictly confidential.

Patients name:	Sex ☐ M ☐ F	Birth Date _____/_____/_____	Marital Status ☐ Single ☐ Widowed	☐ Married ☐ Divorced

Patient Address:	City:	State: Zip:
Home Phone	Cell Phone	Patient's Social Security No.
Other Phone	Email Address:	2nd Email Address:
If employed, Name of Employer:		Business Phone:
Employer's Address if applicable:		Occupation:

Person Financially Responsible ☐ Self: ☐ Name:	Relationship ☐ Spouse ☐ Other	Resp. Party's Birth date _____/_____/_____	Resp. Social Security No. Resp's Phone No.

Reason for visit ☐ Sleep Study ☐ PFT ☐ Other:_____	Referring Physician:	
	Person to Contact in Case of Emergency:	
	Relationship to Patient:	Emergency Phone Number:
Primary insurance(ID Card to be photocopied):	Secondary insurance(ID Card to be photocopied):	

Lifetime Assignments of Benefits/Information Release/Authorization to Treat/Acknowledgement/Consent

I authorize payment of medical benefit. to North Jersey Diagnostics Center. LLC for any services furnished. I understand that 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 that no guarantee, either expressed or implied, have been made to me regarding the outcome of any medical treatments or procedures.

Further I have received copies and read North Jersey Diagnostics Center's Financial and Payment Policy and Notice of Privacy Practices

_____ _____

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

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DURABLE ASSIGNMENT OF BENEFITS AND PAYMENT AUTHORIZATION

Date:_____

Insurance(s):

_____

Subject: Patient Name :_____
Member ID :_____
DOB :_____

To Whom It May Concern:

I,_____, authorize payment of medical service(s) to the provider, North Jersey Diagnostics Center, LLC or all occasions on which they provide me with covered medical services, including but not limited to PSGs, MSLTs, CPAP Titrations, CPAPs/Bi-Levels, equipment rentals, leases & purchases and other diagnostic testing. This authorization is durable and may only be revoked by an express written request signed by myself. Kindly honor this request to expedite matters for all involved.

Please mail check payable to:

NORTH JERSEY DIAGNOSTICS CENTER, LLC
500 Valley Road, Suite 104
Wayne, N.J. 07470

Thank you.

Effective Date of Authorization :_____

_____
(Signature)

_____
(Print Name)

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Patient Name:_____ Patient DOB: _____

I hereby acknowledge that I have read and understand this form and any questions I had were answered to my satisfaction. I hereby agree and accept the terms on this form by affixing my initials.

1. **Medical Treatment**
   I do hereby consent to be tested at North Jersey Diagnostics, LLC. and permit my physician, his/her technician to perform any service or routine diagnostic procedure which the physician deem necessary. I acknowledge that no guarantees have been made as to the result of the tests or examinations in the sleep lab. I also understand that it is possible that this procedure may result in mild and temporary skin irritation. In very rare circumstances skin discoloration can occur.

2. **Release of information**
   I hereby authorize North Jersey Diagnostics, LLC. to release part or all of my medical records to other Medical professions, and/or any insurance company, governmental agency managed care organization, or any other entity or person who may be required to pay all or part of the costs of my treatment and/or outpatient care.

3. **Authorize to Video Tape**
   I authorize North Jersey Diagnostics, LLC. to videotape me during my sleep diagnostic study to facilitate an accurate diagnosis as to the type and severity of any sleep disorder and that all such tapes will be held in the strictest confidence and shared only with medical professionals responsible for my medical care. I understand that I will receive no compensation, whatsoever from any party for permitting such filming.

4. **Assignment of Benefits and Financial Policy**
   Insurance plans with co-insurance/co-pay are the responsibility of the patient and is collected before every treatment is performed.

5. **Personal Valuables**
   I understand that North Jersey Diagnostics, LLC, its trustees, officers, employees are not responsible for loss of, or damage to, property that is kept by me in the sleep lab. I am fully responsible for all articles, jewelry, dentures, eyeglasses, etc. and clothing that I retain in *my* possession (in the room) and for any other articles that may be brought to me while I am a patient in the North Jersey Diagnostics, LLC. clinic

6. **Privacy Practices**
   I acknowledge receipt of Notice of Privacy Practices.

Patient's Signature: _____ Date:_____

_____
(print)

Witness _____ Date:_____

_____
(print)

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Patient Name:_____

Date of Birth : _____ Date of Birth_____

New Patient Visit

1. Describe your sleep problem: _____

   _____

   _____

2. When did your sleep problem begin:_____(month/year)
3. Current Medications: (attach a list if you have):

Medication	Dose/Frequency	Last Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Have you ever had a sleep study performed? _____Yes _____No

   If "Yes", where and what were the results?

   _____

   _____

   _____

5. My occupation is:_____

   My job requires shift work _____Yes _____No My work hours are:_____

6. I have actually fallen asleep while driving a car. _____Yes _____No

   If yes, how often? _____Times

7. I snore _____Nightly _____Weekly _____Rarely _____Never
8. I snore in all sleep positions: _____Yes _____No
9. My snoring has described as: _____Mild _____Moderate _____Loud
10. I stop breathing at night: _____Yes _____No

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11. Please complete the following information for all physicians/healthcare providers you have seen in past 5 years starting with your primary physician.

Send summary to this Doctor

Name	City	Speciality		
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

I authorize North Jersey Diagnostics Center, LLC and its employee to forward my medical information to those perso responsible for my continuing medical care

12. Indicate whether you have ever had any of the following and if so, please describe

Abnormal swelling in legs or feet	☐ Yes	☐ No
Paing in calves when you walk	☐ Yes	☐ No
Awakening at night short of Breath	☐ Yes	☐ No
Arthritis and Rheumatism	☐ Yes	☐ No
AID or HIV	☐ Yes	☐ No
Blackouts or loss of consciousness	☐ Yes	☐ No
Cardiac Arrhytmias	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Congrestive heart failure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hiatal bernia or reflux esophagitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Heart attach	☐ Yes	☐ No
High/Low blood sugar	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No
Pain, Stiffness or swelling in back, muscles	☐ Yes	☐ No
Problems falling asleep, staying asleep	☐ Yes	☐ No
Rapid or irregular heart beats	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Significant Headaches	☐ Yes	☐ No
Skin rash	☐ Yes	☐ No
Daytime Sleepiness	☐ Yes	☐ No
Sleep Apnea, Snoring	☐ Yes	☐ No
Weight loss or gain of more than 100 lbs.	☐ Yes	☐ No

Describe:_____

_____

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Patient Name :_____

Date of Service : _____ Date of Birth_____

The Epworth Sleepiness Scale

PSG#: _____ ID#: _____ ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number of each situation.

0 = Never doze
1 = Slight chance of dozing
2 = Modarate chance of dozing
3 = High chance of dozing

Situation	**Chance of dozing**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place(e.g., theater, meeting)	_____
Passenger in a car for an hour without break	_____
Lying down to rest in the afternoon when circumstancs permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation.

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Patient Name: _____

Date of Service : _____ Date of Birth_____

Pre – Sleep Questionnare

1. What time did you get into bed last night?
2. What time did you get out of bed this morning?
3. How much sleep did you get:
4. Have you have any of the following in the last 24 hours?
   - ☐ Alcohol
   - ☐ Coffee
5. Have you taken routine medications today? If yes please list.

   _____
6. Did anything out of the ordinary happen today? If yes, explain.

   _____
7. How tired do you feel right now?
   - ☐ Not at all
   - ☐ Quite a bit
8. How sleepy do you feel right now?
   - ☐ Not at all
   - ☐ Quite a bit

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Patient Name :_____

Sex : ☐ Male ☐ Female

Tehnician : _____ Date:_____

1. How long did it take you to fall asleep last night after the lights turned off?
   Hours
   Minutes
2. How does this compare with the length of time it usually takes you to fall asleep at home?
   ☐ Longer than usual ☐ Same as usual ☐ Shorter than usual
3. How long did you sleep?
   Hours
   Minutes
4. Compared to the way you felt before lying down, how do you feel now?
   ☐ More rested ☐ Less rested ☐ About the same
5. Did you experience any strange muscle sensation?
   ☐ Yes ☐ No

   If yes, describe:_____
6. Did you experience any strange sounds or sights?
   ☐ Yes ☐ No

   If yes, describe:_____
7. How tired do you feel right now?
   ☐ Not at all ☐ A little ☐ Quite a bit ☐ Extremely
8. How alert do you feel right now
   ☐ Not at all ☐ A little ☐ Quite a bit ☐ Extremely
9. How does this compare to a usual night sleep at home?
   ☐ Better ☐ Much better ☐ About the same ☐ Worse ☐ Much worse
10. If you wore nasal C-Pap last night, did you have any problems with it?
    ☐ Yes ☐ No
11. Would you be willing to wear nasal C-Pap as a nightly treatment?
    ☐ Yes ☐ No

Tehnician:_____

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Patient Satisfaction Survey

Dear Patient:

Thank you for choosing Sleep Diagnostics of New Jersey 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?

- ☐ Dr. referral/suggestion
- ☐ Advertisement
- ☐ Friend/family
- ☐ Personal Knowledge
- ☐ Other

Did the technologist introduce him/herself to you and explain the testing procedure(s)?

☐ Yes ☐ No

Comments:_____

Where 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:_____

Name:_____(not required, but greatly appreciated)

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 the Administrator.

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Patient Name:_____
Date of Birth : _____ Date of Birth_____

Follow-Up Visit

1. Are there any changes in the medications you are taking?

_____

2. Have there been any changes in your medical condition since your last visit here?

_____

Patient Signature: _____

Print Name: _____