



Date: _____

Dear _____,

You are scheduled for sleep testing on _____ at _____. You will be at the Sleep Center all night and will be ready to leave the following morning at 6:00 am. **Please arrive at the lab between 7:30 and no later than 8:00 pm.** (unless prior arrangements have been made). If additional insurance information is needed, you will receive a phone call from the LSC admitting department, prior to your scheduled testing date.

Please use an ink pen to fill out the enclosed questionnaire and sleep diary and bring them with you the night of your study. Make sure that all medications are listed, including exact names and dosages. Also bring any medication that you would normally take at night or the next day. Do not skip any medication, unless directed to do so by your physician.

Please make sure your hair is clean, dry and free of hair spray, gels and conditioners. Gentlemen: Please be clean shaven unless you have a beard &/or mustache. This will help us to acquire a quality study. Feel free to bring your favorite pillow. Please bring any toiletries that you might need for your stay. Out of courtesy to the other patients, we ask that you bring sleep clothes, shorts or pants and something to be worn over your undergarments. You may also want to bring a change of clothing for the next day. There is a microwave and refrigerator available for you to use during your stay at the Lakeside Sleep Center. Decaffeinated coffee, juice and water are provided. You may bring any additional snacks that you would like to have.

A technologist will greet you and explain the procedures for the test. Electrodes and various respiratory measuring devices will be applied to you to monitor your brain waves, breathing and muscle tension. You will go to bed at your regular time. (typically between 10:30-11:00 pm) The technologist will be present throughout the night of testing and will awaken you in the morning when testing is over.

*Do not drink any caffeinated beverages, alcoholic beverages, or take any naps on the day of testing. If you have any questions please call **(352) 343-9943** and speak with Becky. If there is no answer, please leave a message and we will return your call as soon as possible.*

1876 Nightingale Lane • Tavares, FL 34788 • (352) 343-9943

LAKE PULMONARY CRITICAL CARE
Frank J. Montoya, M.D. · Rosemary A. Cirelli, M.D., FCCP

SLEEP HISTORY QUESTIONNAIRE

TO BE COMPLETED ONLY IF YOU ARE HERE FOR EVALUATION OF A SLEEP PROBLEM

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

Your Occupation: _____ # Hours per week _____ Shift _____

Chief Complaint: _____

Have you ever had a sleep Study? Y or N If yes where: _____

History: _____

Sleep Patterns:

Bedtime: _____ Total sleep time: _____ Hours What time do you fall asleep? _____

Wake up time: _____ Get up time: _____ Do you wake up with a Headache? Y or N

Do you feel refreshed? Y or N Do you have a dry mouth? Y or N

Do you have a bed partner? Y or N (if yes) Do they tell you that you snore? Y or N

What is your sleep position? Side Back Prone

Do you stop snoring if you change your sleep position? Y or N, if yes please explain: _____

If you snore have you been told you can be heard in other rooms of the house? Y or N

Have you been told that you stop breathing while you sleep? Y or N

Do you have excessive daytime sleepiness? Y or N Do you take Naps? Y or N if yes how many times?

Per week _____ Duration _____ Do you feel refreshed? Y or N

Did you have sleep problems in your youth? _____

While sleeping do you have any of the following?

Restless legs Y or N Bad dreams Y or N Night Terrors Y or N Walking in your sleep Y or N

Talking Y or N Have you ever injured yourself? Y or N

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

Epworth Sleepiness Scale

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3 with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you doze or fall asleep in that situation.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching Television	0 1 2 3
Sitting inactive in a public place—for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour 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
Sitting quietly after lunch (when you've not had alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score	

Total: _____

Score: 0-10 within normal limits
>12 pathological sleepiness

PLEASE READ OVER THIS INFORMATION CAREFULLY, IT IS VERY IMPORTANT!!!!

This is a general form given to all patients regarding what you **may** be responsible to pay depending on your insurance for your sleep study (s). Any Monies that are due from you will be paid the night of your sleep study; the techs will give you a receipt.

If this is your first sleep study and this study shows that you have sleep apnea, you may be required to undergo a second study, so we have listed the prices for both studies. These studies are 2 different charges so you will pay for EACH study.

These percentages are based on the allowed amount (allowed amounts vary with each insurance) for the procedure codes listed. Please be advised this amount is an estimate based on verbal communication with your insurance and does not guarantee this is your payment in full, or that the procedures are covered under your plan. These are just estimates. All insurances disclose that verbal communication does not change the terms of your contract, and nothing can be 100% until they actually receive the claim and process it. If you would like to call your insurance company yourself with any coverage questions (most insurance companies cover sleep studies, but we are not always told of exclusions on policies) or other questions you will need the following information: The 1st sleep study is procedure code 95810 & the 2nd study with C-pap titration is 95811 and be sure to tell them the study is performed in the office setting and NOT an out-patient facility. When we bill the place of service is OFFICE.

FOR MEDICARE PATIENTS (normally what ever % you pay in the office is what % you will pay for your study(s). IF YOU HAVE A 2ND INSURANCE THAT COVERS ALL YOUR CHARGES AFTER MEDICARE AND YOU NORMALLY DO NOT PAY IN THE OFFICE THEN YOU WILL NOT BE EXPECTED TO PAY AT THE TIME OF YOUR SLEEP STUDY(S). We will bill both Medicare & your secondary and if there is a balance you will be billed accordingly. Keep in mind if for any reason your deductible is not met, you will receive an additional billing for your deductible or any part of your deductible that is not met. For the year 2010:

Procedure	Allowed Amount	20%	½ of the 20%	20% of the 20%
95810	\$752.13	\$150.43	\$75.22	\$30.07
95811	\$830.563	\$166.11	\$83.06	\$33.22

FOR BCBS MEMBERS use the table below: If you have a co-pay that covers all services performed in an office setting, not just an office visit charges, then you will pay the same co-pay for each sleep study that you pay in office. If you have a deductible and/or co-insurance (what you pay after your deductible is met) you will be asked to pay by the following table. If you have deductible that is not met we check with BCBS the morning of your sleep study to see if has been met and we base what we collect on what we are told that day. If for any reason we over collect once we receive all payment in full from your insurance you will be refunding (normally within one week of our office receiving that payment from your insurance, please note any monies that due from you for other charge will be taken from that refund.) The allowed amount is what you will pay if your deductible is not met.

Procedure	Allowed Amount	20%	15%	10%
95810	\$833.02	\$154.06	\$110.22	\$77.03
95811	\$918.00	\$173.57	\$130.18	\$86.79

FOR ANY OTHER INSURANCE not listed you will be called the day of your study with the amount that will be due that night. See above information you would like to contact your insurance company directly with any questions you may have.

If you have any questions regarding the amount that will be due or if you are unable to pay amount due in full you may call our billing office at 742-4447 ex 207 to discuss options.



NAME _____ WEEK _____

Note: Start each day after arising from bed in the morning	Day 1 Date:	Day 2 Date:	Day 3 Date:	Day 4 Date:	Day 5 Date:	Day 6 Date:	Day 7 Date:
Did you NAP? How often? How Long? When?							
Did you consume any alcohol or non-prescribed drugs? What? How much? When?							
Are you now taking prescribed medication? What? How much? What?							
Have you had any liquid other than water? (coffee, tea, carbonated beverages) What? How Much? When?							
When did you go to bed?							
How long did it take you to fall asleep?							
Did you wake up during the night? How often? How long all together?							
What time was your final awakening?							
What time did you get out of bed?							
How did you feel upon the final awakening?							
How long did you sleep last night?							