PATIENT INFORMATION

PLEASE PRINT.

Last Name: ___________________________ First Name: __________________________ M.I.: _______

SSN: _____________________________ Email: ____

Street Address: ____ Apt: __________

Zip Code: _____________________ City: __________________ State: ___________

(______)___________________ (______)___________________ (______)___________________
Home Phone Number *Work Phone Number + EXT* *Mobile Phone Number*

Date of Birth: ____/____/____ **Sex: ◻ M ◻ F**

Referring Doctor: _____________________________

How did you hear about us? ____________________________

Location of Appointment: ______________________________

INSURANCE INFORMATION

PLEASE ENTER THE FOLLOWING INFORMATION FOR THE PERSON THAT IS THE PRIMARY CARD HOLDER FOR YOUR INSURANCE.

Name of Insurance Company: ____ (Copy of Card Required)

Last Name: ___________________________ First Name: __________________________ M.I.: _______

(______)___________________ (______)___________________ (______)___________________
Home Phone Number *Work Phone Number + EXT* *Mobile Phone Number*

Street Address: ____ Apt: __________

Zip Code: _____________________ City: __________________ State: ___________

Subscriber/Policy I.D.: ____ Group #: _____________

Relationship to Patient: _______________________________________ Date of Birth: ____/____/____

Type of Coverage: Group Plan Individual Plan

PRIVACY COMMUNICATION FORM

In complying with the health information privacy act, HIPAA, we want to make sure that we guard your privacy according to your wishes when it comes to family, friends, and co-workers.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

May we contact you via email for treatment follow-up?	**YES**	**NO**
May we leave messages on an answering machine at home?	**YES**	**NO**
May we leave messages on a voicemail at work?	**YES**	**NO**
May we discuss your appointments/treatments with your spouse?	**YES**	**NO**
May we leave messages concerning your appointments/treatments with a co-worker, receptionist or secretary that regularly answers your calls?	**YES**	**NO**
Are there persons other than yourself (i.e. spouse, children or other family members, etc.) that you would wish us to discuss your appointments/treatments with if requested? If so, please list name and relationship below.	**YES**	**NO**

Name ***Relationship***

1. ____

2. ____

3. ____

4. ____

You must inform us, in writing, of any changes in your directives. This record takes effect on the date below and will be kept in your file along with your acknowledgements of receipt of our Notice of Privacy Practices.

Signature: ____ **Date:** ____/____/____

Witness Signature: ____ **Date:** ____/____/____

RELEASE OF INFORMATION

I authorize The Snoring Center to release any medical information requested by representatives of local, state or federal agencies, insurance companies or other organizations or entities as may be required by said representatives for pay of claims arising out of these medical services as are due The Snoring Center.

Signature: ____

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MEDICAL HISTORY FORM

Name: ____ Age: _______ Birthdate: __________________________

How did you hear about us? ____

Name and address of your primary care provider (your regular family doctor): _______________________________

____ Phone: ___________________________

Reason for today's visit? ____

Have you ever had a sleep study? ☐ No ☐ Yes: Date: _________________ Where: __________________________

Results: ____

PAST HISTORY

PLEASE LIST ANY PRIOR MAJOR ILLNESSES AND/OR INJURIES.

____

____

PLEASE LIST ANY SURGERIES OR HOSPITILIZATIONS	YEAR	COMPLICATIONS

PLEASE LIST CURRENT MEDICATIONS INCLUDING ASPRIRIN:

DRUG	DOSE	FREQUENCY	DRUG	DOSE	FREQUENCY

*PLEASE LIST ANY ALLERGIES OR REACTIONS TO MEDICATIONS AND/OR OTHER MATERIALS:*_____________________________

Are you currently taking testosterone? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

Subjective Nasal Obstruction?
☐ Nasal Steroid?
☐ Antihistamine?
☐ Nasal Strips?

Do you drink alcohol? ☐ Yes ☐ Daily ☐ One or more times a week ☐ Occasionally
☐ No

What is your occupation? (Or if retired, prior occupation) ____

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SNORING HISTORY

How old are you? _______

At what age did you begin snoring? ______ At what age did your snoring become a problem? _______

How much did you weigh 5 years ago? ______ 10 years ago? ________ As a teenager? _______

How tall are you? ________ feet ________ inches

What is your neck sixe (circumference)? ______ inches

Who complains about your snoring? ____

How do people describe your snoring? ____

____

____

Have you been told that you stop breathing while you sleep? ___________________________________

Are you a "restless" sleeper? ____

What time do you usually go to bed? ______________

What time do you usually fall asleep? _____________

What time do you usually wake up? _____________ Average number of hours of sleep per night: _____

Do you wake up feeling refreshed? ___________

Do you have headaches in the morning? ___________

How is snoring affecting you quality of life? ____

____

____

How many nights per week do you sleep apart from your partner for all or part of the night because of your snoring? _____________

How long have you slept apart because of your snoring? _________________

Does anyone in your family have sleep apnea? ________________________________

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REVIEW OF SYMPTOMS

ARE YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

CONSITITUTIONAL		
Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO
EYES		
Double Vision	YES	NO
Visual Loss	YES	NO
Hearing Loss	YES	NO
Noise/Ringing in Ears	YES	NO
Nasal Congestion	YES	NO
Nasal Drainage	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO
CARDIOVASCULAR		
Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO
NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO
ALLERGIC/IMMUNOLOGIC		
Sneezing	YES	NO
Itchy Eyes/Nose	YES	NO
Itchy Throat	YES	NO
Skin Rash	YES	NO
HIV	YES	NO

RESPIRATORY		
Asthma	YES	NO
Cough Up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing at Night	YES	NO
Snoring	YES	NO
GASTROINTESTINAL		
Indigestion or Heartburn	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood in Stool	YES	NO
Black, Tarry Stool	YES	NO
GENITOURINARY		
Bladder Trouble	YES	NO
Prostate Disease	YES	NO
Kidney Disease	YES	NO
MUSCULOSKELETAL		
Arthritis	YES	NO
ENDOCRINE		
Diabetes	YES	NO
Thyroid Disease	YES	NO
HEMATOLOGIC		
Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO
PSYCHIATRIC		
Depression	YES	NO
Other	YES	NO

The above information is accurate to the best of my knowledge.

Signature: ____ Date: _______________________

I have reviewed the above information with the patient. _____________________

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THE EPWORTH SLEEPINESS SCALE

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 affect you. Use the following scale to choose the most appropriate number for 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 TV	
Sitting inactive in public place (e.g. a theater or a meeting)	
Riding 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	
Riding in a car, while stopped for a few minutes in traffic	
	TOTAL

NASAL OBSTRUCTION SYMPTOM EVALUATION

Over the past month, how much of a **problem** were the following conditions for you?

PLEASE CIRCLE THE ANSWER.

	Not a problem	Very mild problem	Moderate Problem	Fairly bad problem	Severe problem
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get air through nose during exercise or exertion	0	1	2	3	4

MEDICARE ADDENDUM

The Snoring Center and its physicians have opted out of Medicare and do not participate with Medicare in any way.

This agreement is between the Snoring Center, Dr. Craig Schwimmer (and any other physicians of The Snoring Center) and patient:

___________________________ (Patient), who resides at ____
and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1977. The Physician has informed Patient that Physician has opted out of the Medicare program effective 11/17/2008 for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to patient:

In exchange for the services, the patient agrees to make payment to The Snoring Center pursuant to the fee schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right as a Medicare beneficiary to obtain Medicare-covered items and services from physicians and practitioners who have opted-out of Medicare and that the patient is not compelled to enter private contract that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understand that Medicare payment will not be made for any items or services furnished by Physician that would otherwise be covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.

____	___________________________________
Patient Name	*Patient Signature / Date*
____	___________________________________
Patient Name	*Patient Signature / Date*

PATIENT FINANCIAL RESPONSIBILITY AND ARBITRATION FORM

Patient Name: ______________________________ DOB: __________

The Snoring Center appreciates the confidence you have shown in choosing us to provide for your medical needs. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

The services you have elected to receive carry a financial responsibility on your part. The responsibility obligates you to ensure and guarantee payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved coverage, you will be responsible for your balance in full. I understand that Dr. Schwimmer has a financial interest in Pillar Palatal, LLC, the company that makes the Pillar Procedure.

Agreement to Arbitrate: It is the intention of the parties that any dispute that may arise out of or relate to services or treatments provided by the physician will be subject to arbitration as provided by Texas law, and not by a lawsuit or resort to court process except as Texas law provides for judicial review of arbitration proceedings. The binding arbitration is to be held in Dallas County, Texas, in accordance with the then-current rules of the American Arbitration Association (AAA) for the resolution of disputes (the Rules). The parties further agree that any arbitration will be administered by the AAA and that the arbitrator shall be selected in a manner consistent with the Rules. The decision of the arbitrator shall be final and binding on the parties of arbitration. Judgment may be entered on the arbitrator's decision in any court having jurisdiction.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility and Arbitration Form:

Patient Signature ______________________________ Date ____________

Guarantor Signature ______________________________ Date ____________
(if guarantor is not the patient)

FEES AND PAYMENT POLICY

The following outlines our policy regarding fees, payment and third party claim reimbursement. We are committed to providing excellent service at a reasonable cost and will attempt to make your experience as convenient as possible.

In general, insurance companies do not reimburse expenses for snoring treatment. All fees for services provided are due in full **at the time of service**. The Snoring Center has contracted with Blue Cross Blue Shield, Aetna, United Healthcare and Cigna, but is considered an “out of network” provider by all other carriers. **Please note that the insurance filling is not a substitute for payment.**

The fee for an initial consultation is your insurance carrier’s allowable for a specialist office visit. We do not provide ongoing claims tracking (e.g. follow-up, appeals, etc.). **You will be responsible for the status of your claim and for appealing any denial if you choose to do so.**

If the patient is a Medicare Part B Beneficiary, he/she must complete the attached Medicare Addendum. The Snoring Center and its physicians have opted out of Medicare. The patient understands and agrees not to submit a claim and that Medicare payment will not be made for any items or services furnished by The Snoring Center.

PLEASE SELECT FROM THE FOLLOWING OPTION TO DEFINE HOW YOU WOULD LIKE THE SNORING CENTER TO ASSIST YOU REGARDING INSURANCE FILINGS FOR TREATMENTS:

☐ **Option One:**

The Snoring Center will file your claim for your treatment on your behalf.

OR

☐ **Option Two:**

The Snoring Center will provide the documentation necessary for you to file your own claim.

Patient Signature: ____

Date: _____ / _____ / _____

Witness Signature: ____

Date: _____ / _____ / _____