



Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ Home Tel: (____) _____ Cell: (____) _____

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Sex: Male Female Marital Status: Single Married Widowed Divorced Language: English Spanish Other: _____

Race: White Black Asian Other: _____ Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Email: _____

Pharmacy Name: _____ Phone: (____) _____

Pri Care Prov: _____ Phone: (____) _____ Fax: (____) _____

Referring Prov: _____ Phone: (____) _____ Fax: (____) _____

Employer: _____ Phone: (____) _____ Occupation: _____

RESPONSIBLE PARTY:

Guardian Name: _____ D.O.B: ____/____/____ Patient Lives With: _____

Mom's Name: _____ Social Security Number: _____ - _____ - _____

Address (if different): _____ City: _____ ST: _____ Zip: _____

D.O.B: ____/____/____ Email: _____

Employer: _____ Work #: (____) _____ Cell #: (____) _____

Dad's Name: _____ Social Security Number: _____ - _____ - _____

Address (if different): _____ City: _____ ST: _____ Zip: _____

D.O.B: ____/____/____ Email: _____

Employer: _____ Work #: (____) _____ Cell #: (____) _____

HEALTH INSURANCE: *A photocopy of these assignments shall be valid as the original

*PRIMARY INSURANCE: _____ Policy # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

Insured's SS#: _____ - _____ - _____ Relationship to the patient: _____

*SECONDARY INSURANCE: _____ Policy # _____ Group # _____

Insured's Name: _____ Insured's DOB: ____/____/____

Insured's SS#: _____ - _____ - _____ Relationship to the patient: _____

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary. I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize Sleep Medicine Specialists of South Florida, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to Sleep Medicine Specialists of South Florida, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE OF GUARDIAN/RESPONSIBLE PARTY: _____ DATE: _____



Date: _____

Patient Name: _____ DOB: _____

Sex: Male Female *If female, are you pregnant?* Yes No

Chief Complaint/Reason for visit: _____

Current Medications (please include over the counter medications, herbals, and vitamins):

Past surgeries, major medical events/hospitalizations: _____

Allergies: None _____

Past Medical History (ongoing chronic medical problems): _____

Family History: Dad: _____ Mom: _____

Siblings: _____

Social History: Caffeine (Type/Amount – include coffee, sodas, tea and energy drinks): _____

Alcohol (Type/Amount): _____

Tobacco: Lifetime non-smoker? Yes No

If former smoker: How many packs per day? _____ How many years? _____

What year did you quit? _____

If current smoker: How many packs per day? _____ How many years? _____

Pre-bedtime activities: _____

Work schedule (Days of week and time): _____

Exercise (times/week, time/session): _____



Date: _____ **Patient Name:** _____ **DOB:** _____

Epworth Sleepiness scale:

How likely are you to doze off or fall asleep in the following situations, especially over the last 2 weeks? Even if you haven't done any of these activities during recent times, try to estimate how you would have been affected.

0 = no chance of dozing off
1 = slight chance of dozing off
2 = moderate chance of dozing off
3 = high chance of dozing off

1. Sitting and reading a book, magazine or newspaper?	
2. Watching television?	
3. Sitting inactive in a public place? (ie. in the doctor's office, at the movie theater)	
4. As a passenger in a car for an hour without a break?	
5. Lying down to rest in the afternoon when circumstances permit?	
6. Sitting quietly after lunch without alcohol?	
7. Sitting and talking to someone?	
8. In a car, while stopped for a few minutes in traffic?	
The total Epworth Sleepiness Scale today is (sum of 1-8 above)	

Adapted from: Murray W Johns. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale, Sleep, 1991; 14 (6): 540-545.

STOP BANG questionnaire:		
1. Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
2. Tired: Do you often feel tired, fatigued, or sleepy during daytime?	YES	NO
3. Observed: Has anyone observed you stop breathing during your sleep?	YES	NO
4. Blood Pressure: Do you have or are you being treated for high blood pressure?	YES	NO
5. BMI: BMI more than 35 kg/m ² ?	YES	NO
6. Age: Age over 50 yr old?	YES	NO
7. Neck circumference: Collar size greater than 16 in. (or 40 cm)?	YES	NO
8. Gender: Are you a male?	YES	NO
Adapted from: Chung F, Yegneswaran B, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology. 2008 May;108(5):812-21.		



CONSENT TO TREATMENT

I, _____, hereby authorize Sleep Medicine Specialists of South Florida P.A., the attending physician, or the physician designated by him or her and other employees to examine and treat me. I also authorize such treatment and procedures as deemed necessary by the physician, including but not limited to sleep studies, the taking of X-Rays, medications, blood samples, urine samples and other therapies.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee or assurance has been made or implied to me as to the results that may be obtained by examination and treatment.

I HEREBY CERTIFY THAT I UNDERSTAND THE ABOVE AUTHORIZATION.

Patient (Sign and Print)

Date

Guardian/Responsible Party if minor (Sign and Print)

Date

Witness (Sign and Print)

Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Sleep Medicine Specialists of South Florida, PA's Notice of Privacy Practices.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to Patient

FOR PRACTICE USE ONLY:

Sleep Medicine Specialists of South Florida, PA made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:



BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT: The client agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the services of the undersigned provider of services, including any partners, agents, or employees of the provider shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT: The client further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the services provided by the undersigned provider or the provider's agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL: Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS: All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES: If either party contends that the injuries claimed and/or issues arose out of the rendering of medical care, the parties agree to recognize that the provisions of Florida Statute Section 766 governing medical malpractice claims shall apply to the parties and/or claimants in all respects except that unless at the conclusion of pre-suit there is no mutual agreement to arbitrate under Florida Statute 766.106 or 766.207, the parties and/or the claimants shall resolve any claim through arbitration pursuant this Agreement. Within fifteen (15) days after parties to this Agreement have given written notice to the other of a demand for arbitration of said disputed controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection therefore to the parties. The arbitrator shall hold a hearing within a reasonable time from the date of the notice of selection of a neutral arbitrator. The parties agree that the arbitration proceeds are private, not public, and the privacy of the parties and of the arbitrator shall be preserved. If the parties proceed to arbitration pursuant to Florida Statute Section 766, as indicated above, then the arbitration proceeds shall be in accordance with that statutory section. Otherwise, these arbitration proceedings apply.

6. ARBITRATION EXPENSES: Expenses of the arbitration shall be shared equally by the parties to this Agreement.

7. APPLICABLE LAW: Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 *et seq.* In conducting the arbitration under Florida Statutes, Section 682.01 *et seq.*, all substantive provisions of Florida law governing medical

Patient Initials: _____



malpractice claims, including **but not limited to** caps on damages, Florida’s Wrongful Death Act, the standard of care for medical providers, and the statute of limitations set forth in Florida Statute Section 95.11(4)(b) shall apply. **Expert witness testimony will be required to support any allegations of a deviation in the standard of care. Said expert testimony will be governed by the Florida Rules of Evidence, Florida Evidence Code, and Florida Statutes Chapter 766.**

8. EFFECT OR REFUSAL TO PROCEED WITH ARBITRATION: In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this Arbitration Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party’s absence at the arbitration hearing.

9. SEVERABILITY: If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision **and the parties still want to arbitrate any claims arising out of or related to medical care.**

10. ACKNOWLEDGMENTS BY PATIENTS: The client by signing this Agreement, also acknowledges that he or she has been informed that:

a. NO DURESS: The Agreement may not be submitted to a client for approval when the client’s condition prevents the client from making a rational decision whether or not to agree;

b. AGREEMENT BASED UPON OWN FREE WILL: The decision whether or not to sign the Agreement is solely a matter for the client’s determination without any influence by Sleep Medicine Specialists of South Florida, P.A. and/or its agents or employees;

c. RECEIPT OF COPY OF AGREEMENT: I have received a copy of this Agreement;

d. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL: Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

Patient (Sign and Print)

Date

Guardian/Responsible Party if minor (Sign and Print)

Date

Witness (Sign and Print)

Date



ARBITRATION EXPLANATION

Many of our patients have questioned why Sleep Medicine Specialists of South Florida, P.A. is requiring our patients to sign an arbitration agreement. Many are concerned that this means they are giving up the right to sue and also their right to compensation for any situation in which they might have a legitimate complaint against the doctor or his/her office. This is in fact not the case and not our intent.

Lawsuits are the most common method of resolving disputes in this country. Unfortunately, the process of reaching a resolution is an extremely long, complicated and often painful process for all of those involved. Most suits drag on for years before a jury ever reaches a verdict, which then also delays any required compensation. The extended time period creates added expense for both sides and reduces the potential recovery for the patient.

Arbitration is a much more efficient process; the arbitrators are chosen by both sides and are professionals who are trained to help arrive at a more timely conclusion. The process will also be much less disruptive to the life of both the patient and doctor and less expensive. It is for these reasons that we have chosen to use arbitration as our method of resolving disputes.

As always, we will strive to provide quality medical care and service to our patients, and we hope that the arbitration system will rarely if ever be needed by our patients.

Q: What is Arbitration?

A: Arbitration is the process of resolving disputes in front of a panel of neutral arbitrators.

Q: Am I giving up my right to sue?

A: No, Arbitration takes the place of and avoids a lengthy jury trial. This document simply states that you must go through the arbitration process, in order to find a neutral resolution.

Q: Why are we doing this?

A: Traditionally, medical malpractice suits have been resolved through litigation and a process that is time consuming, expensive and stressful for both sides. The high financial and emotional costs of litigation have given rise to binding arbitration, which is an alternative method for resolving disputes. The Arbitration process has proven to be faster and less costly to both parties involved.

Q: What happens if I do not sign?

A: If you are an existing patient, in the middle of treatment and refuse to sign the arbitration agreement, after the treatment for the current problem has completed you will be provided with a 30 day notice to find another physician.

If you are a new patient or an existing patient that has not been seen for a while and is not in current treatment, you will not be seen.

Arbitration is not new and has been used by physicians since 1920, with the ever increasing costs, arbitration has become more popular and a viable alternative to resolving disputes in the courts.