PATIENT DEMOGRAPHICS

NAME: ____
FIRST NAME M.I. LAST NAME

ADDRESS: ____

______________________, ________, ____________
CITY STATE ZIP

DOB: ____________________ SS#: ______________________

MARRIED SINGLE SEPARATED OTHER

HOME #: __________________ WORK: _________________ EXT _______ CELL _______________

EMPLOYER: ____

ADDRESS: ____

______________________, ________, ____________
CITY STATE ZIP

SPOUSE: __________________________________ WORK: ___________________

EMPLOYER: ____

REFERRING PCP: ____

ADDRESS: ____

______________________, ______, __________
CITY STATE ZIP

PHONE #: _________________________ FAX: _________________________

INSURANCE INFORMATION:

PRIMARY:

____ ______________________________
NAME PHONE#:

____ ______________________________
ID NO GROUP

__________________________________ ____________________ ________________
INSURED RELATIONSHIP TO PT INS DOB

SECONDARY:

____ ______________________________
NAME PHONE#

____ ______________________________
ID# GROUP

__________________________________ ____________________ ________________
INSURED RELATIONSHIP TO PT INS DOB

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IF THIS IS DUE TO WORKERS COMPENSATION INJURY ----- INFORM RECEPTIONIST

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RELEASE AND ASSIGNMENT – TO MY INSURANCE CARRIER (S):

I authorize the release of any medical information/documentation necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician/TSDC. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in lieu of the original. I understand that I am financially responsible for all charges incurred regardless of my insurance coverage. I understand that I will be financially responsible for any late fees, collection agency fees and attorney fees due to failure to pay charges for services rendered.

____ ________________________
PATIENT SIGNATURE **DATE**

TALLAHASSEE SLEEP DIAGNOSTIC CENTER

INFORMED CONSENT

Welcome to the Tallahassee Sleep Diagnostic Center, a free standing, full-service sleep center. The center is nationally accredited by the American Academy of Sleep Medicine. This letter informs you of certain conditions associated with this practice of sleep medicine. Please read this carefully and entirely and sign in the appropriate place thereby acknowledging and documenting that you have read this informed consent.

** The practice of Sleep Disorders Medicine is limited to those disorders affecting sleep and arousal, or causing excessive daytime sleepiness.

** Many sleep disturbances depend upon the successful identification and treatment of the underlying disorder. Some examples of underlying disorders/conditions are depression, anxiety and pain during sleep, which may be an unrecognized cause of your sleep disturbance. After identification of the sleep disturbance, including any underlying problems, a care and treatment plan will be pursued. This might include referral to another physician for treatment of any underlying disorders/conditions, with your permission.

** Those sleep disorders which are specific to sleep alone, such as sleep-induced breathing Disorders, narcolepsy, sleep walking, dream-enactment behaviors, etc., would be managed by a sleep specialist in medicine.

** **Twenty-four hour coverage is not available**, nor is it necessary for a sleep disorder. Although overnight sleep testing is performed here, the night time technical staff is not knowledgeable in the management and treatment of sleep disorders, and the staff is of a technical/testing nature rather than medical/professional. No reliance on the staff should be placed for your medical sleep inquiry or opinions regarding medical issues either in person or by phone. Prescription refills are available only during regular working hours, Monday through Friday. **Please make sure you always have several days of medication on hand so that you will "not run out" after hours or during the weekend or Holidays. AGAIN, 24 HOUR IS NOT AVAILABLE.**

** If a perceived side effect from medication occurs, discontinue the medication promptly, then inform the Sleep Diagnostic Center as soon as possible during regular office hours. **NO EMERGENCY AFTER – HOUR CARE IS AVAILABLE THROUGH THE SLEEP DIAGNOSTIC CENTER.**

We are very pleased that you have chosen the Tallahassee Sleep Diagnostic Center for evaluation. Please acknowledge with your signature below that you have read this informed consent and agree with acceptance of the conditions stated.

______________________________ ______________

PATIENT SIGNATURE **DATE**