VIRGINIA SLEEP SPECIALISTS

Jonathan Gellman MD
www.virginiasleepspecialists.com

Patient Information

First Name: _____ Last Name: _____ Preferred Name: _____

Address:_____

City, State, Zip: _____

Home Phone: _____Work Phone: _____Ext: _____Cell:_____

Birth Date: _____ Soc Sec #:_____E-mail Address_____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Other

Emergency Contact Name:_____

Relationship to Patient:_____

Emergency Phone #:_____

Primary Care Physician's Name & Phone#:_____

Preferred Pharmacy:

Name:_____ Location (intersection): _____

Responsible Party: (if different than patient)

Relationship to Patient: □ Spouse □ Parent □ Other _____

First Name: _____ Last Name: _____

Address (if different from above):_____

City, State, Zip: _____

Home Phone: _____ Cell:_____

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Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____Policy #: _____

Group #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

SSN: _____-_____-_____

Patient Relationship to Policy Holder:

_____

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize Virginia Sleep Specialists, physicians, practitioners and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment. I authorize the providers to administer such treatment as they deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the provider and I consent to care by such provider. I understand these services are voluntary and that I have the right to refuse these services.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

PAYMENT AND BILLING POLICY

We appreciate that you have entrusted us with your healthcare. Because healthcare benefits and coverage options have become increasingly complex, it is your responsibility to know your insurance benefits (i.e. copays, coinsurance, deductibles, preferred providers/hospitals, referrals, preauthorizations, recertifications, limits on outpatient charges, non-covered services, etc.). Your health plan determines your coverage, requirements, and limits to your coverage. We will do our best to assist you with understanding your proposed treatment and in answering any insurance questions you may have.

You, as the patient or responsible party, are responsible for all fees, copays, coinsurance, and/or deductibles regardless of insurance coverage.

As a courtesy, we will file your claims to your insurance carrier. In the event your insurance company has not paid the charges within 90 days, you and/or the responsible party will be responsible for the balance due. **You will only receive a statement from us after your insurance carrier has responded to your claim. Payment is due upon receipt of statement.** It is also your responsibility to obtain referrals from your primary care provider when necessary. If the referral is not obtained before the visit, the patient and/or responsible party will be liable for payment in full at the time of the visit. If we are unable to obtain payment within a reasonable amount of time, we will place your account with a collection agency and you may be liable for additional expenses.

Self-pay patients will be asked for a portion of their balance at the time of service. Payment arrangements can be made, if necessary, on the remaining balance. We accept cash, personal checks, MasterCard and Visa.

We understand that financial problems arise from time to time. Let us know if you need to arrange a payment program to pay your balance in monthly installments. Our business office staff will gladly assist you with these arrangements.

I have fully read and understand the above statement of payment policy. I hereby assign to Virginia Sleep Specialists any benefits paid on my behalf. I authorize Virginia Sleep Specialists to release my health information to obtain reimbursement for the provision of health care services. I understand that Virginia Sleep Specialists does not accept partial payments made by insurance carriers as full payment for the services rendered, and I will be responsible for any charges not covered by insurance.

I understand that this authorization is valid until I choose to revoke it.

Signature:_____ Date:_____

Name Printed: _____

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MEDICAL RECORD RELEASE REQUEST

PLEASE FAX RECORDS TO 757-351-4255

HIPAA Privacy Authorization Form Effective Date: 07/01/2021

PATIENT_____ D.O.B._____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization. I authorize _____ (healthcare provider) to use and disclose protected health information described below to the healthcare provider known as Virginia Sleep Specialists (healthcare provider seeking the information) and the business entity known as Gellman Medical LLC(business seeking the information)

2. Effective Period. This authorization for release of information covers all past, present, and future periods of health care.

3. Extent of Authorization. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. Use. This medical information may be used by Hypnos Sleep Consultants PLLC and Hypnos Health Inc and I authorize them to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. Termination. This authorization shall be in force and effect until the death of Patient, at which time this authorization form expires.

6. Revocation Rights. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. Benefits. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. Disclosure. I understand that information used or disclose pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law

Records Requested:_____

Patient's Signature (or Personal Representative): _____

"***PATIENT NAME"_____

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Date: _____

Sleep and Health History

Patient Name: _____

Date of Birth:_____

Sleep Problem

In your own words, briefly describe your sleep-related problem:

_____

_____

_____

=Yes = No Have you ever been diagnosed with a sleep disorder ?
=Yes = No Have you ever had your tonsils or adenoids removed?
=Yes = No I am currently prescribed =CPAP or = Bilevel pressure.
Settings _____
=Yes = No Oxygen during the =day or =night _____ liters per minute.
=Yes = No I have had surgery for a sleep disorder = UPPP = Tonsillectomy
= Other_____
=Yes = No I use a dental device for sleep disordered breathing.
Has an immediate blood relative had any of the following?
= Obstructive sleep apnea = Narcolepsy = Other sleep disorders?

_____

Sleep Breathing

=Yes = No I have been told that I snore loudly.
=Yes = No I have been told that I stop breathing while asleep.
=Yes = No Does your bed partner complain about you snoring?
=Yes = No Do you ever wake up choking or gasping for air?
=Yes = No I have been awakened by my own snoring?
=Yes = No I have trouble breathing when flat on my back?
=Yes = No I have morning headache.
=Yes = No I sweat a great deal at night.
=Yes = No I have been told that I snore only when sleeping on my back.

Sleepiness

=Yes = No I often feel drowsy during the day, more than I expect is normal.
=Yes = No I feel unrefreshed or tired in the morning despite sleeping at night.
=Yes = No I take daytime naps. How many? _____
=Yes = No I have uncontrollable urges to fall asleep during the day.
=Yes = No I have experienced lapses in time or blackouts.
=Yes = No I have fallen asleep while driving.
=Yes = No I performed poorly in school or work because of sleepiness

Sleep Habits

Typical bedtime: _____ weekday _____ weekend
Typical awakening time: _____ weekday _____ weekend
Typical hours in bed: _____ hours.
Typical hours of sleep: _____ hours
Typical amount of time it takes to fall asleep _____ (in minutes)
Typical number of awakenings per night: _____
How many naps do you take in a typical week? _____For how long?_____
Do you usually only wake up to use the restroom?_____ How many times?_____

Sleep Environment

Typical sleep position(s) = back = side = stomach = head elevated = in a chair
My bedroom is comfortable = noise =too warm = too cold
=Yes = No I share a bed with someone.
=Yes = No I have pets in the bedroom.
=Yes = No I watch TV in bed prior to sleep.
=Yes = No I read in bed prior to sleep.
=Yes = No I work or study in bed.
=Yes = No I drink alcohol prior to bedtime.
=Yes = No I eat a snack at bedtime.
=Yes = No I eat if I awaken during the night.
=Yes = No I smoke prior to bedtime or when I awaken during the night.

Leg Symptoms

=Yes = No I kick or jerk my legs excessively during sleep.
=Yes = No This bothers my bed partner.
=Yes = No I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.
=Yes = No I experience an inability to keep my leg still prior to falling asleep.
=Yes = No I experience the feeling of restlessness in my legs at night.

Orexin Symptoms

=Yes = No I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise.
=Yes = No I experience an inability to move while falling asleep or when waking up.
=Yes = No I have experienced hallucinations or dreamlike images when falling asleep or waking up.
=Yes = No I frequently dream during daytime naps.

Parasomnias

=Yes = No I act on my dreams while asleep.
=Yes = No I have frequent nightmares.
=Yes = No I talk in my sleep.
=Yes = No I have sleep walked.

Other

=Yes = No I frequently travel across two or more time zones.
=Yes = No I am more alert in the morning than evening.
=Yes = No I am more alert in the evening than morning.
=Yes = No I awaken alert in the morning earlier than it is time to get up.
=Yes = No I frequently have heartburn or acid reflux at night.
=Yes = No I feel depressed.
=Yes = No Chronic pain interferes with my sleep.
=Yes = No The need to urinate frequently interrupts my sleep.
=Yes = No I grind my teeth in my sleep.
=Yes = No I have bedwetting (enuresis).
=Yes = No I have trouble falling asleep.
=Yes = No Thoughts start racing through my mind when I try to fall asleep.
=Yes = No I have trouble remaining asleep.
=Yes = No I awaken frequently during the night.
=Yes = No I have difficulty returning to sleep if I awaken during the night.

Habits

=Yes = No I smoke cigarettes (or other tobacco). If yes, how much?_____
=Yes = No I drink alcohol. If yes, how much and how often?_____
=Yes = No I drink caffeinated beverages during the day_____cups/bottles/cans
= tea = coffee = soda per day

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Health History

My Primary Care Doctor is _____ = I do not have a primary care doctor.

Please check any of these illnesses that you have or have had in the past:

Heart Disease = High Blood Pressure = Low Blood Pressure =
Abnormal Thyroid = Congestive Heart Failure = Seizures =
Diabetes = Asthma = Hearing Trouble =
Cancer = Nasal Congestion = Prostate Problems =
Mental Problems = Fainting = COPD =
Depression = Anxiety =

Other medical conditions =:

_____

_____

Female: = Premenstrual syndrome = Menopause

Male: = Prostate problems = Erectile dysfunction

Please list any surgeries that you have had with date: _____

_____

Please list all allergies you have :

_____

_____

General History

=Yes = No Do you exercise?
=Yes = No Do you use over the counter sleeping pills to help you sleep?
=Yes = No Does your sleep problem interfere with work or school? =Yes = No
Weight change during the past year = gained _____ pounds = lost _____ pounds
= No change

Social History

Marital status: = Single = Married = Separated = Divorced = Widowed

Employment status:
= Employed: Occupation _____
= Unemployed = Disabled = Student = Retired

=Yes = No Regularly work night shifts.
=Yes = No I work rotating shifts, including night shift work

Medications

Name of Medication	Dose and Frequency

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REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last **MONTH**.

Constitutional/General
- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain
- ☐ Other:_____

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Wear Glasses
- ☐ Other:_____

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Mouth Sores
- ☐ Nasal Congestion/Sinus Issues
- ☐ Hearing Loss
- ☐ Other:_____

Respiratory
- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath
- ☐ Other:_____

Endocrine
- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes
- ☐ Other:_____

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ Other:_____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion or Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties
- ☐ Other:_____

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Other:_____

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising
- ☐ Bleeding Tendencies
- ☐ Other:_____

Genitourinary
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating
- ☐ Other:_____

Skin
- ☐ Skin Rash
- ☐ Itching
- ☐ Discoloration of the Skin
- ☐ Lumps or Masses
- ☐ Other:_____

Musculoskeletal
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking
- ☐ Other:_____

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Convulsions/Seizure
- ☐ Other:_____

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Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

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

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

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	___
Watching TV	___
Sitting, inactive in a public place (e.g. a theatre or a meeting)	___
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	___
In a car, while stopped for a few minutes in the traffic	