Sleep Wake Disorder Center of Daytona, PA

810 Wildwood St, Suite 1
Daytona Beach, Florida 32117
P: (386) 258-7100 F: (386) 253-1843

Your Appointment is scheduled on: **at:**

Today's Date:

Name: ☐ M ☐ F Date of Birth:

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone: Email:

SSN: Ethnicity/Race:

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Spouse/Partner Name: Phone No.:

Emergency Contact: Phone No: Relationship:

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Employer: Occupation: Work Phone No.:

Primary Care Doctor: Referring Doctor:

Insurance Information:

Primary Insurance Name:	Secondary Insurance Name:
Address:	Address:
Insured Name: DOB:	Insured Name: DOB:
Policy ID:	Policy ID:
Group #:	Group #:
Employer Name:	Employer Name:
Employer Address:	Employer Address:
Phone No.:	Phone No.:
Relationship of Patient to Insured:	Relationship of Patient to Insured:
I hereby authorize SWDC and the undersigned physicians to release any information acquired during the course of my examination for treatment to my referring physician or insurance carrier listed above.	Do we have permission to: - Leave a voicemail on your answering machine? ☐ Y ☐ N - Leave a message at your place of employment? ☐ Y ☐ N - Send a text or email message? ☐ Y ☐ N

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. It is also customary to pay for service when rendered unless other arrangements have been made in advance with the office billing department.

I request that payment of authorized medicare/insurance company benefits be made to me or on my behalf to Sleep Wake Disorder Center of Daytona Beach (Dr. Wahba W. Wahba), for any services furnished by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply.

Signature: Date:

SWDC Representative/Scanned: Date:

Sleep/Wake Disorder Center of Daytona, PA
810 Wildwood Street Ste. 1
Daytona Beach, FL 32117
Phone (386) 258-7100
Fax (386) 253-1843

Consent for Purposes of Treatment
Information Release Form

Name:_____D.O.B_____

Consent to Treatment

I hereby give my permission for the providers of Sleep Wake Disorder Center of Daytona, PA to examine, treat, and prescribe medication(s) for the condition(s) I present with.

Signature: _____ _Date:_____

Release of Information

I consent to the release of information of medical records and/or the discussion of my condition to family and caregivers as listed below.

☐ Yes

☐ No

If yes, please name those valid individuals:

Name: Phone Number:

1) _____

2) _____

3) _____

Signature:_____ Date:_____

SWDC Staff Notes:

SLEEP-WAKE DISORDE CENTER OF DAYTONA, PA FINANCIAL POLICY

Patient Responsibility
You are financially responsible for the services we provide you at Sleep-Wake Disorder Center of Daytona, PA (SWDC). As a courtesy, we will file insurance claims on your behalf, when you have supplied SWDC with current and precise insurance information. If you present without this information, please be prepared to either pay cash or reschedule your visit. It is your sole responsibility to know the individual coverage and benefits of your insurance plan. It is your responsibility to ensure our practice is a contracted provider with your plan. If you fail to keep this information updated, your claim may be denied and you will be responsible for any charges due for services rendered.

Patients Without Insurance (self-pay)
It is our pleasure to provide services to patients that do not have insurance. However, you will be expected to pay for your services at the time of the visit. We do not bill self-pay accounts. Estimations of cost can be discussed with our Billing Department prior to scheduling to plan for anticipated cost of services.

Medicare Patients
SWDC accepts Medicare assignment. We will bill your secondary insurance if you provide us with the proper insurance information. You are, however, solely responsible for any coinsurance, deductibles, or any charges for non-covered services. You will be required to sign an advanced beneficiary notice for any procedure performed.

Private Insurance Patients
SWDC accepts assignment for most major insurances. It is your responsibility to confirm that we are a contracted Provider with your plan. You will be required to pay any applicable copayments, coinsurance, deductibles, and/or any non-covered services rendered or ordered by the clinic Providers at SWDC.

HMO Patients
It is the patient's responsibility to ensure our practice is a contracted provider, and that your Primary Care Physician has obtained prior authorization from your insurance carrier. If your plan requires referrals to specialty physicians you must adhere to your plan and our practice referral policy. If you seek care without prior authorization, you will be financially responsible for the specialist visit(s).

We Do Not File Third Party Liability Insurance Claims
We will provide medical care for you in accident cases, but will only file with your medical insurance or accept cash at the time of visit.

Methods of Payment
We accept cash, checks, Visa, MasterCard or Discover cards only. A $20.00 charge will be assessed for any returned checks (NSF).

Prior Balances
Patients with an account showing a prior balance will be asked to pay the balance in full before being seen. If the balance cannot be paid in full, you may be asked to meet with our billing department to arrange for payment.

Form Charges
There will be a charge assessed for the completion of any disability, insurance, or special forms. Rates are $25.00 for one to multiple pages. These charges are not covered by insurance carriers and are due at time of service, in addition to any applicable office visit fees.

Information Change
Please advise us of any address, phone number, or insurances changes promptly. You will be asked at least once a year to fill out new demographic information, or to initial that what is on file is current and correct.

Appointments: Reschedule and Cancelations
Please notify SWDC at least 24 hours in advance if you must cancel or reschedule your appointment. This allows us time to schedule another patient. Patients with consecutive missed or cancelled appointments will be billed a $25.00 charge per missed appointment and may be dismissed from SWDC and will need to find a new Provider accepting their plan.

Collection Procedures
Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in your account being turned over to an outside collection agency and discharge from our practice. If your insurance company has not paid your account in full within 120 days, you will be billed the balance. Balances on accounts that are not paid after 2 billing cycles (60 days) will be sent a 'final notice" letter. If still not satisfied within 30 days, the account will be turned over to an outside collection agency at that time.

I HAVE READ AND AGREE TO THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY SWDC. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO AFMC. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

_____

Patient Name **Patient Signature** **Date**

_____

Name of Parent/Guardian of minor **Parent/Guardian Signature** **Date**

SWDC Staff Member: _____ **DATE:** _____

Medical History Form

Review Of Systems: (Please Check off all that are present at this time)	
General:	☐Fever, ☐Chills, ☐Weight Loss, ☐Weight Gain
HEENT:	☐Change in Vision, ☐Blurry Vision, ☐Sore Throat, ☐Dry Mouth, ☐Grind Teeth, ☐Ear Ringing, ☐Ear Pain, ☐Hearing Loss
Respiratory:	☐Cough, ☐Wheezing, ☐Shortness of Breath, ☐Sputum ☐Coughing up Blood
Cardiac:	☐Chest Pain, ☐Racing Heart Beats, ☐Leg Swelling, ☐Atrial Fibrillation, ☐Heart Attack ☐Sleep on Multiple Pillows due to Breathing, ☐Wake up Gasping for Air
Gastrointestinal:	☐Abdominal Pain, ☐Constipation, ☐Diarrhea, ☐Nausea, ☐Vomiting, ☐Reflux
Neurologic:	☐Seizures, ☐Headaches, ☐Dizziness, ☐Numbness, ☐Tingling
Psychiatric:	☐Depression, ☐Anxiety, ☐Hallucinations
Endocrine:	☐Heat Intolerance, ☐Cold Intolerance, ☐Diabetes, ☐Hypothyroidism
Hematologic:	☐Easy Bruising, ☐Easy Bleeding, ☐Anemia, ☐Blood Clot
Sleep:	☐Snoring, ☐Pauses in Breathing, ☐Sleepy during the Day, ☐Insomnia

Medical Conditions: (Please check any that you have been diagnosed with)

Sleep:	**Endocrine:**	**Neurological:**	☐ALS
☐Sleep Apnea	☐Diabetes	☐Cerebral Palsy	☐Parkinsons Disease
☐Restless Leg Syndrome	☐Type I	☐Muscular Dystrophy	☐Alzheimer's Disease
☐REM sleep Behavior D/O	☐Type 2	☐Multiple Sclerosis	☐Down's Syndrome
☐Insomnia	☐Hypothyroidism	☐Stroke	**Psychiatric:**
☐Periodic Limb Movements	☐Hyperthyroidism	☐Seizures	☐Autism
☐Narcolepsy	☐Cushing's Disease	**Cardiac:**	☐ADHD
☐Idiopathic Hypersomnia	☐Low Testosterone	☐Heart Attack	☐Depression
	☐Erectile Dysfunction	☐Stent Placement	☐Anxiety
Pulmonary:	☐PCOS	☐Defibrillator	☐Bipolar Disorder
☐COPD	**Gastrointestinal:**	☐Atrial Fibrillation	☐PTSD
☐Asthma	☐Heartburn/Reflux	☐Heart Failure	☐Schizophrenia
☐Pulmonary Fibrosis	☐IBD (Crohn's)	☐Pacemaker	**Cancer:**
☐Lung Cancer	☐Celiac Disease	☐Coronary Bypass	
☐Pulmonary Nodule	☐Gallstones	☐High Blood Pressure	
		☐High Cholesterol	

Surgical History:

☐Appendix	☐Septum			☐Weight Loss Surgery
☐Gallbladder	☐Sinuses			☐Gastric Sleeve
	☐Knee Replacement:	☐R	☐L	☐Gastric Bypass
☐Tonsils	☐Hip Replacement	☐R	☐L	Other:
☐Adenoids	☐Shoulder Replacement	☐R	☐L	

Social History:

Smoking	☐Yes	☐No	☐Quit Amount: PPD Years		
Alcohol Use	☐Yes	☐No	☐Amount: drinks/wk		Kind:
Drug Use	☐Yes	☐No	☐Amount: uses/wk		Kind:
Marital Status	☐Married	☐Engaged	☐Single	☐Divorced	☐Widowed
Employment Status	☐Fulltime	☐Parttime	☐Retired	☐Student	☐Unemployed
Caffeine Use	☐Yes	☐No	Amount: cups/day		Kind:
Physical Activity	☐Yes	☐No	Amount: days/wk		Kind:

Family History:

Mother	☐Alive	☐Deceased	Conditions:
Father	☐Alive	☐Deceased	Conditions:
Siblings:			
	☐Alive	☐Deceased	Conditions:
	☐Alive	☐Deceased	Conditions:
	☐Alive	☐Deceased	Conditions:

Allergies to Medications:

Medication List:

	Medication Name, Dose, Frequency
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Pharmacy:	Name:
	Location:
	Phone:
Secondary Pharmacy:	Name:
	Location:
	Phone:
Mail Order Pharmacy:	Name:
	Location:
	Phone:

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EPWORH SLEEPINESS SCALE

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Name Date of Birth Date

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?
This refers to your way of life in recent times.
Even if you haven't done some of these things recently, try to work out how they would affect 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

SITUATION	**CHANCE OF DOZING**			
Sitting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching Television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in a public place (ex: 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 when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Total: _____