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:*** ___________________

****

Emergency Contact: ____________________________ ***Relationship:*** _________________ ***Phone:*** (_____) _____________

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI), such as your spouse or other family member? **(CIRCLE) YES NO (if yes…additional form required)**

Do you have any restrictions on how you would like to be contacted? **(CIRCLE) YES NO (if yes…addition form required)**

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? **(CIRCLE) YES NO If YES, Phone#:** (_____) __________________________

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 the information about the 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: ____ ***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. ***S*****noring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
2. ***T*****ired:** Do you often feel tired, fatigued, or sleepy during daytime?	YES	NO
3. ***O*****bserved:** Has anyone observed you stop breathing during your sleep?	YES	NO
4. **Blood *P*ressure:** Do you have or are you being treated for high blood pressure?	YES	NO
5. ***B*****MI:** BMI more than 35 kg/m^2?	YES	NO
6. ***A*****ge:** Age over 50 yr old?	YES	NO
7. ***N*****eck circumference:** Collar size greater than 16 in. (or 40 cm)?	YES	NO
8. ***G*****ender:** 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

1350 SW 57 Avenue; Suite 210 Miami, FL 33144
777 E. 25 Street; Suite 320 Hialeah, FL 33013
8726 NW 26 Street; Unit # 3 Doral, FL 33172
Telephone: (305) 994-1825 Fax: (305) 508-5519 Email: info@southfloridasleeps.com Website: www.southfloridasleeps.com

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 than 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 to 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.