Suburban Sleep
& PULMONARY MEDICINE

Dear Valued Patient,

We are delighted to have you as a new patient to our practice. This welcome packet has been designed to help us build your patient profile. Our goal is to thoughtfully guide you through the patient experience before, during, and after your scheduled appointment. Thank you for entrusting us with your care.

Before Your Appointment

- Complete the patient forms: You will need your medical history, insurance information, and credit card on hand. ALL forms need to be completed, prior to scheduling your appointment.

- Submit Welcome Packet Using one of the Following Methods:
  - EMAIL: sleepbetter@suburbansleep.com
  - US MAIL ***Please allow 7-10 business days for this method***
  - DROP OFF AT OUR OFFICE (Mailing address is the same)

ARLINGTON LOCATION:
3421 N. Arlington Heights Rd.
Arlington Heights, IL 60004
FAX: (847)797-1903
PHONE: (847)797-1933

JOLIET LOCATION:
3077 W. Jefferson St. #210
Joliet, IL 60435
FAX: (815)773-9099
PHONE: (815)773-9090

Our Communication to You

- WAIT FOR A CALL
- One of our friendly office coordinators will call you to schedule an appointment.

What to Bring to Your Appointment

- Insurance card
- Photo identification
- Co-pays, co-insurance and any outstanding balances, are due at check-in.
- Any other specific instruction that was requested when scheduling your appointment.
- If you have had one or more **sleep studies** in the past, we must have copies of these at the time of your visit. Our staff may be able to assist you in locating them. If you cannot obtain your prior studies, please understand that you may have to repeat them in order to further your care.
- If you have a **CPAP or BiPAP device**, bring it with your mask to the appointment.

During Your Appointment

- Our clinical team will take the time to get to know you, listen to your concerns, and develop the best plan of care for you. We will assist you with coordinating and scheduling any necessary testing and follow-up appointments during the check-out process

Start Filling Out Your Forms Here

Patient Demographics

LAST NAME:_____ FIRST NAME: _____ MI: _____

DOB: _____ SEX: M F

STREET ADDRESS: _____ APT #_____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE: _____ **(CIRCLE ONE)** CELL LAND LINE

SECONDARY PHONE: _____ **(CIRCLE ONE)** CELL LAND LINE

EMAIL: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP TO PT: _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____ RESPONSIBLE PARTY: _____

MEMBER ID: _____ GROUP # _____

SECONDARY INSURANCE (IF APPLICABLE): _____

MEMBER ID: _____ GROUP #_____

PHYSICIAN INFORMATION

We need the full name and contact information of the physician who suggested you find a sleep physician, or wrote an order referring you directly to Dr. Warren. This is important for the continuity of your care, so please take a moment to find the information we are asking below:

NAME OF PHYSICIAN (who recommended you see a sleep doctor)

PHYSICIAN LAST NAME_____ PHYSICIAN FIRST NAME_____

PHONE # _____

CITY & STATE OF THE PHYSICIAN'S PRACTICE: _____

OFFICE LOCATION FOR YOUR VISIT

Clinic Locations

JOLIET LOCATION: 3077 W JEFFERSON ST SUITE 210, JOLIET, IL 60435

ARLINGTON LOCATION: 3421 N ARLINGTON HEIGHTS RD, ARLINGTON HEIGHTS IL, 60004

PLEASE NOTE*: IF YOU NEED TO CANCEL YOUR APPOINTMENT, KINDLY CALL OUR OFFICE 815-773-9090, AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT. WE HAVE A $100 MISSED APPOINTMENT FEE, WHICH WILL BE CHARGED TO THE CREDIT CARD WE HAVE SECURED IN YOUR ELECTRONIC HEALTH FILE.*

Our Communication to You

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We are looking forward to meeting you!

GENERAL SLEEP HISTORY

Today's date: _____

Last name: _____ First name: _____ MI: _____

Date of birth: _____ Height: _____ Weight: _____

Describe your sleep problem: _____

_____

_____

What is your usual bedtime? _____ Wake-up time? _____

How long does is usually take to fall asleep? _____

Do you awaken frequently from sleep? Y N

Do you have frequent nightmares? Y N

Do you act out your dreams? Y N

Are you tired during the day? Y N

Do you nap regularly? Y N

Do you snore? Y N

Has anyone told you that you stop breathing during sleep? Y N

Do you awaken during the night coughing, choking, or gasping for air? Y N

Do you often awaken with headaches? Y N

Do you often awaken with heartburn? Y N

Do you get up in the middle of the night to urinate? Y N If yes, how many times? _____

Has your dentist or bed partner told you that you grind your teeth while sleeping? Y N

Do you often awaken from sleep with your heart pounding? Y N

Has your weight changed over the past 5 years? Y N If yes, by how much? _____

Given the following situations, how likely are you to fall asleep. Use the following rating scale:

0 – Never
1 – Slight chance
2 – Moderate chance
4 – High chance

Sitting and reading? _____

Watching television? _____

Sitting in a public place (i.e. a theater or meeting)? _____

As a passenger in a care for one hour? _____

Lying down to rest in the afternoon? _____

Sitting and talking to someone? _____

Sitting quietly after lunch without alcohol? _____

While driving a car, stopped for a few minutes in traffic? _____

TOTAL _____

**** If you ever had a sleep study, please bring a copy to your first appointment.**

**** If you have a CPAP device, please bring it to your first appointment.**

MEDICINE RECORD

Today's date: _____

Name (Last, First, Middle Initial)	Birth Date (mm/dd/yyyy)
	/ /

WHAT I'M USING **Rx - Brand & generic name;** **OTC - Name & active ingredients**	**DOSAGE**	**FREQUENCY**	**REASON (or medical condition)**

Guarantee of Payment
Suburban Sleep and Pulmonary Medicine

Arlington Heights Office
3421 N. Arlington Heights Rd
Arlington Heights, IL 60004-1356

Joliet Office
3077 W. Jefferson Suite 210
Joliet, IL 60435-5264

I, the Credit Card Holder, understand that by signing this document I am guaranteeing payment to Suburban Sleep and Pulmonary Medicine for services provided to the patient listed below (patient may or may not be the same as cardholder). If I am not the Patient, I understand that I am not entitled to view the patient's medical record under the Hospital Insurance and Portability Act (HIPPA), unless the Patient is a minor.

I understand the patient's insurance carrier may make payments for all or part of the medical service visits, and for equipment and supplies provided to the patient. I agree that I am responsible for all deductibles and co-payments not covered by the insurance carrier, and for all charges denied by the insurance carrier. Payment is due upon receipt of statements showing balance due.

By providing this credit card number, I agree that Suburban Sleep and Pulmonary Medicine may charge my card for unpaid balances after two (2) unpaid monthly statements mailed to the patient's home address or email address on file with The Sleep Center.

I understand that this credit card will be charged a $100 fee for a missed new patient office visit, and $50 for a missed follow-up office visit, if a 24-hour notice is not given.

Checks returned for insufficient funds will result in a $35.00 charge to cover bank service fees. In addition, if the patient's unpaid account is transferred to a collection agent, a fee of 28% of the total amount due, plus any necessary attorney fees, will be added to the balance due.

I have read and understand all of the terms and conditions outlined above. **Please initial here**: _____.

Credit Card Information

Name as it appears on card: _____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Credit Card Type: _____

Number: _____

Expiration: (_____ /_____) Security Code: _____

Signature of credit card holder: _____ Date: _____
If my signature is different from name on this credit card, I have stated to the witness that I am an authorized user of this credit card.

Signature of patient (or guardian) _____ Date: _____
If cardholder is not the patient, this signature authorizes cardholder to obtain information about the nature of any and all charges.

Witness: _____ Date: _____

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Acknowledgment of Privacy Notice

I, _____(Patient Name), hereby affirm that I have read a copy of the *Privacy Practice Notice* from Suburban Sleep.* Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement signifies only that I have received/reviewed a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient or Personal Representative

Signature_____ Date _____

Name of Patient or Personal Representative

_____Relationship to patient _____

Suburban Sleep Representative

Signature _____ Date _____

*Suburban Sleep includes: Suburban Sleep and Pulmonary Medicine/Kramer Medical Supplies

Suburban Sleep and Pulmonary Medicine

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Assignment of Benefits Agreement

My signature below is required to allow Suburban Sleep* to do each of the following:

1. Request assignment of Medicare, Medicaid, Medicare Supplemental or private insurance benefits for medical services, sleep studies, and purchased medical equipment and supplies. Directly bill Medicare, Medicaid, Medicare Supplemental or private insurer(s)

2. Release my medical information to Medicare, Medicaid, Medicare Supplemental or private insurers and their agents and assigns.

3. Obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical equipment supplies.

4. Contact me by telephone, email, or US mail regarding my medical services and/or equipment supply order.

I request that payment of Medicare, Medicaid, Medicare Supplemental or private insurance benefits be made on my behalf to Suburban Sleep for medical equipment and supplies furnished to me. I authorize my physician(s), caregivers, CMS, its agents, and to my medical insurers to release any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all allowable amounts that are not covered by my insurer(s) and for which I am responsible.*

Patient Name (print)_____

_____ _____
Signature Date

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Alternate Contact Information

In the event that Suburban Sleep* is unable to contact me, I give my permission to use the following alternate contact method(s):

☐Yes ☐No --Speak with anyone at my residence

☐Yes ☐No --Speak with _____ Relationship to Pt.:_____

☐Yes ☐No --Leave a message on my voice mail/answering machine

☐Yes ☐No --Email me for my follow up contact. Email Address: _____

Patient's Printed name: _____

_____
Signature & Date

(If signature is different from Pt., this is Pt.'s guardian and the relationship to Pt. is: _____)

Suburban Sleep is required to have an emergency contact on file. Please list name and phone number(s) of emergency contact:

Alternate contact name: _____

Relationship to patient: _____

Phone Number(s): _____

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