UNITED DIAGNOSTICS

SLEEP STUDIES • VEEG • DME

PHONE: (866) 711-1299
FAX: (888) 539-3001
www.uniteddx.com

Patient Name:_____

You have been scheduled for the following test on Date:_____

Please arrive between 8:00 PM and 9:00 PM

☐ **Polysomnography (Overnight Sleep Study):**
This test will terminate at no later than 6:00 a.m. the following morning (arrangements can be made for a different wake time at time of test, if needed).

☐ **CPAP or Split Night Sleep Study:**
This test will terminate at no later than 6:00 a.m. the following morn ing (arrangements can be made for a different
wake time at time of test, if needed).

☐ **Polysomnography with Multiple Sleep Latency Testing {MSLT):**
This test will terminate at approximately 4:00 - 6:00 p.m. the following day. This test involves trials of napping at pre-assigned intervals throughout the day. The test involves a minimum of 4 naps and a maximum of 5. Please pack an overnight bag. Please bring breakfast and lunch for the following day as well. Please do not drink caffeine the following day and do not eat turkey.

***All testing will take place in the Laboratory, United Sleep Diagnostics, Inc,**
You will be sleeping in a private bedroom.

Parking is available in selected labs. (Please inquire upon scheduling)

NOTE:

- **If the patient is under the age of 18 or is disabled and unable to legally sign for him/herself, a parent or legal guardian must accompany patient and be present throughout testing.**

- The results of the sleep study will be available approximately within 5 to 10 business days after the date of your test.

Because a sleep study is so involved and requires extensive 'set-up' time, we ask that, for any reason, you are unable to keep your appointment; you give us at least 48 hours notification. Failure to provide this notification will result in a $250 fee being charged to you directly. (This is not covered by insurance)

Measurements are painless and include:

- Placement of electrodes on your scalp, sides of the face, under the chin and behind ears.
- Heartbeat (EKG) - On upper chest.
- Leg movements- Sensors placed on both legs.
- Breathing- Bands strapped around the chest and abdomen. Flow sensor taped on upper lip.
- Oxygen Saturation- Plastic sensor taped to the finger.

Please bring with you a list of medications, which you are taking. Take all medications prescribed by your physician(s), as you normally would. Please consult your physician if you have any questions.

On the day of the test:

- ***Do not take naps during the day or drink beverages that contain caffeine or alcohol after 2PM.***

- Men should preferably shave and woman should avoid excessive make-up.
- Please remove acrylic nails.
- Please remove hairpieces.
- Please shower and wash your hair on the day of the test.
- Bring something to sleep in (preferably two piece pajamas with buttons in front or a T-shirt and shorts), slippers, toiletries, reading materials, medications or any snacks that you need.
- If you have any favorite sleeping item, such as a pillow, feel free to bring it with you.
- The United Sleep Diagnostic Center is not responsible for any items left in the lab.

Following the test:

- We attempt to utilize hypoallergenic tape and non-irritating solutions. Even so, it is advisable to shower following the study to minimize the likelihood of skin irritation from any materials/solutions.

If you are unable to arrive on time, please call:
Before 5:00 pm: (866) 711-1299
After 5:00 pm: (866) 711-1299 & press 4

About Insurance Billing for Your Sleep Study:

Your physician has recommended that you undergo a procedure called Overnight Polysomnography. This is a standard medical test which has a technical component, performed by United Sleep Diagnostics< Inc, and an interpretation component, performed by According to patients Insurance. Ordinarily, insurance will pay for both components of this test, if you have insurance, which covers outpatient testing. The test is an expensive one, as it requires technicians to be monitoring you throughout the night with the use of complex equipment. Fees for this test range from approximately $3,000-5,000. The Center participates in many insurance programs, as well; the Interpreting Physicians participates in many insurance programs. If there is any conflict between the coverage for these two components, United Sleep Diagnostics Inc will notify you prior to the study date. If you do not have insurance coverage, arrangements can be made for out of pocket payment by calling (866) 711-1299. If you have any concerns about this, you may wish to contact our Billing Department for clarification prior to your sleep study.

FOR MEDICARE PATIENTS ONLY:

Medicare requires that we inform you that you are responsible for the 20% provided you do not have secondary insurance. This co-payment will be automatically billed by United Sleep Diagnostics to any secondary insurance carrier you list.

- Please bring all of your **insurance identification cards.** if your insurance issues one. Please be sure to provide us with the proper mailing address of the insurance carriers.

- We must receive any **HIP Referrals** or **pre-authorization from your PCP** (if required by your insurance plan), prior to the study; otherwise your **study may be cancelled.** All referrals for sleep studies should be made out to the specified physician below and authorizations made out to **United Sleep Diagnostics**.

(Provider Name: ***United Sleep Diagnostics,Inc*** Tax ID#: **205208718)**

The Sleep Center will make every effort to ensure that your sleep study is not a financial hardship. If you have further **BILLING** concerns, please call the **Billing Department at (516 873-6500)**

Nassau • 50 Rose Place - 2nd Floor • Garden City Park, NY 11040 PH: 516-873-6500

Nassau • 560 Northern Boulevard • Great Neck, NY 11021 PH: 516-873-6500

Suffolk • 6080 Jericho Turnpike - Lower Level • Commack, NY 11725 PH: 516-873-6500

Brooklyn • 9101 4TH Avenue Brooklyn, NY 11209 PH: 516-873-6500

Manhattan • 199 3rd Avenue - Lower Level, NY NY 10003 PH: 516-873-6500

"EVERYBODY DERSERVES A GOOD NIGHTS SLEEP"

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For Internal use only
CRM Patient ID#

Date: _____

PATIENT REGISTRATION FORM Please provide your insurance card to the Technician

Last Name: _____ First Name: _____ MI: _____ Generation: _____

Guarantor: _____ Ethnicity: _____

Is this guarantor a legal representative Yes ☐ No ☐ Referring Physician: _____

Social Security No: _____ Sex: M ☐ F ☐

Home Address: _____ Rent ☐ Own ☐ Date of Birth: _____

Address Line 2: _____ Martial Status

City: _____ State: _____ Zip Code: _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employer: _____ Emolument Status (check one)

Employer Address: _____ Employed ☐ Retired ☐

Home Phone: _____ Cell: _____ Full-time Student0 Part-time Student ☐

Work Phone: _____ Ext: _____ E-mail: _____

Primary Insurance

Insurance Company: _____ Group Number: _____ Co-Payment Amount: _____

Policy Number: _____ Deductible: _____ *Effective Dates*

Relationship to Insured: _____ From: ____/____/____

Policy Holder Information To: ____/____/____

Last Name: _____ First Name: _____ MI: _____ Generation: _____

Policy Holder Address: _____

Address Line 2: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Employer Address: _____ Employee ID: _____

Secondary Insurance

Insurance Company: _____ Group Number: _____ Co-Payment Amount: _____

Policy Number: _____ Deductible: _____ *Effective Dates*

Relationship to Insured: _____ From: ____/____/____

Policy Holder Information To: ____/____/____

Last Name: _____ First Name: _____ MI: _____ Generation: _____

Policy Holder Address: _____

Address Line 2: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Employer Address: _____ Employee ID: _____

Name of local friend or relative: _____ Relationship to patient: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to United Diagnostics. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information to process my claims.

Patient/Guardian Signature: _____ Date: _____

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CONSENT FOR TREATMENT

I _____, consent to medical treatment for myself or for the patient whom I am either the parent of or authorized legal representative. All procedures and treatments have been explained to me. I understand the reason for medical treatment and/or testing.

CONSENT FOR VIDEO MONITORING

I _____, understand the it is necessary to have a video recording of my sleep study in order to properly identify and treat any findings or indications that may be presented on the night of my sleep study. I understand that the video tape is used only for medical purposes and for my safety.

CONSENT FOR MEDICAL RECORDS RELEASE

I _____, (the patient or authorized legal representative of the patient) consent to the release of medical information to my referring physician and any parties listed below.

Physician(s) Name and Contact Information: _____

_____

_____

Signature of Patient: _____

Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative: _____

Date: _____

Rev: 1/16

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BILLING PRACTICES

PLEASE READ THIS LETTER IN ITS ENTIRETY AS IT CONTAINS IMPORTANT INSURANCE INFORMATION

Dear Patient,

You are receiving this letter because you have chosen to participate in an overnight sleep study or AVEEG administered by United Diagnostics. We have billed your insurance carrier for services rendered.

We partner with multiple insurances and for the ones we are non-participating with you as the insurer, may have all correspondence and/or payments sent directly to you. It is imperative that, upon receipt of such items, you forward them directly to our office.

The insurance check should be endorsed by the policy holder and directly underneath the signature should be written ***"Pay to the order of United Diagnostics".*** This will prevent the check from being cashed by anyone else. To avoid any billing errors please also include any explanation of payment you receive to our office as well.

Included in the envelope addressed to the billing off should be the following items:

- **Endorsed check**
- **Copy of Explanation of Payments**

If you chose to cash the insurance check **(NOT RECOMMENDED)** you may send a personal check for the amount due. **NOTE:** there will be a $35.00 fee of bounced checks.

As a reminder, if this bill is not paid in a timely manner and we are forced to institute collection efforts, you will be responsible for any reasonable costs incurred in that effort, including but not limited to collection fees, attorney fees, and court costs. Should you have any further questions or concern please contact this office.

Sincerely,

Billing Department

50 Rose Place• Garden City Park, New York 11040• Ph. (866) 711-1299• Fax (888) 539-3001
www.uniteddx.com

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENTS

Private and Group Accident and Health Insurance

I hereby direct and instruct _____ Insurance Company to pay by check made and mailed to:

United Diagnostics
50 Rose Place
Garden City Park, NY 11040

If my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

United Diagnostics
C/O: 50 Rose Place
Garden City Park, NY 11040

For the professional or medical expense benefits allowable and otherwise payable to me under my current policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Should the provider not participate with my insurance company, I understand that I will receive payment for the services rendered directly. I agree to send payment along with any correspondence and/or explanation of payment to the provider. Should I fail to forward payment to the provider and it becomes necessary for my account to be placed for collection, I understand and agree that I will be responsible for any reasonable cost incurred in the collection process to include but not limited to, attorney fees, collection fees, etc.

I authorize this provider to institute a complaint to the Insurance Commissioner for any reason on my behalf. I also authorize the release of any information pertinent to my case to any Insurance Company, Adjuster, or Attorney in this case.

Date: _____

_____
Signature of Policy Holder

Member ID# _____

_____
Signature of Claimant (if other than Policyholder

Rev: 1/16

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SKIN QUESTIONNAIRE

1) Are you allergic to anything? Yes ☐ No ☐

If yes please list _____

_____

2) Do you have skin sensitivity to the following:

- Soap Yes ☐ No ☐
- Shamp Yes ☐ No ☐
- Laundry Detergent Yes ☐ No ☐
- Perfume Yes ☐ No ☐
- Body/Moisturizing Loation Yes ☐ No ☐
- Hand Cream Yes ☐ No ☐
- Make-Up Yes ☐ No ☐
- Eggs Yes ☐ No ☐

If yes checked yes to any of the above please describe the skin reaction: _____

_____

_____

3) Do you sunburn easily Yes ☐ No ☐

4) Do you have skin reaction to GOLD/SILVER Yes ☐ No ☐

5) Do you have latex sensitivity? Yes ☐ No ☐

6) Do you have psoriasis? Yes ☐ No ☐

7) Do you have eczema? Yes ☐ No ☐

I understand and acknowledge that there could be skin breakdown due to the sleep study monitoring

Patient Name: _____

Patient Signature: _____ Date: _____

Technologist Applying Electrodes: _____

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UNITED DIAGNOSTICS PARTICIPATES WITH THE FOLLOWING INSURNACES

- 1199
- AARP
- Anthem BC/BS
- Blue Cross Blue Shield
- Blue Cross MA
- Centerlight
- Champva
- Clover
- Core Source
- Elderplan
- Emblem
- Fresenius
- GHI
- Healthnet Federal Services (Tricare)
- Humana
- HIP
- Local Unions
- Magnacare
- Metroplus
- MVP
- Medicare
- Railroad Medicare

United Diagnostics is Affiliated with the following Hospitals

1) St. Joseph Hospital — Bethpage, NY
2) Mercy Hospital — Rockville Centre, NY
3) St. Catherine of Siena — Smithtown, NY
4) St. Charles Hospital — Port Jefferson, NY
5) Good Samaritan Hospital — West Islip, NY

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ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits - Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Provider and their affiliated law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ☐ File medical claims with the health plan
- ☐ File appeals and grievances with the health plan
- ☐ Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff In such lawsuits and actions If necessary (or me as guardian of the patient if the patient Is a minor)
- ☐ Discuss or divulge any of my personal health information or that of my dependents With any third party including the health plan

I certify that the health insurance information that I provided to Provider Is accurate as of the date set forth below and that I am responsible for keeping it updated.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

United Diagnostics participates with the attached list of insurances and are affiliated with the attached lists of hospitals. As a participating provider we have contractual pricing with the plans we participate with and are obligated as such to collect any deductibles, co-payments and co-insurance. If your Insurance plan is one in which we are non-participating with we will then accept negotiated rates based upon the usual and customary fee schedule, disclosing any out-of-pocket expenses you as the patient will incur.

Authorization to Release Information

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan {or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me In writing.

ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action Including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such Insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action In connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to· act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided In 29 C.F.R. §2560.5031{b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

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PRIMARY INSURANCE

Insurance Company: _____Member's ID# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to United Diagnostics all benefits, if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. My signature below authorizes submission of this claim by provider, as well as any and all medical appeals on my behalf.

The above named company may use my health care information and my disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will be in force for one year from the date signed below.

Date: _____

_____
Signature of Patient/Parent/Guardian/Personal Representative

_____
Please print name of Patient/Parent/Guardian/Personal Representative

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provided to you tells you how we may use and share your health information.

- We will use and share your health information or health records to treat you and to bill for the services we provide.
- We will use and share your health information or records to run our business.
- We will use and share your health information or records as required by law.

Your Rights to Health Information of Health Records.

- You have the right to look at and receive a copy of your health records.
- You have the right to receive a list of whom we have given your health records to.
- You have a right to ask for us to correct a mistake on your health records.
- You have a right to ask that we do not use or share your health records.
- You have the right to ask us to change the way that we contact you.

I acknowledge that I have received and read a copy of the Notice of Privacy Practices as Provided by United Diagnostics.

Name of Patient: _____

Signature:_____(Patient or Authorized Legal Representative)

Date: _____

CONSENT

I consent to the use and sharing of my health information of records for the purposes of treatment, payment for treatment, operation purposes as described in the Notice of Privacy Practice, and as required by law.

Name of Patient: _____

Signature:_____(Patient or Authorized Legal Representative)

Date: _____

BILLING ACKNOWLEDGEMENT

I acknowledge that I have received and read a copy of the Billing Practices as provided by United Diagnostics.

Initial: _____

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MEDICAL HISTORY FORM

Name _____ Date_____

Date of Birth_____ Height _____Weight_____ Neck Size_____

Reason for Study/Chief Complaint _____

Other complaints - check all that apply

☐	Snore	☐	Acid taste in	☐	Shortness of	☐	Shift work
☐	Tired	☐	Breathing	☐	Problems falling	☐	Difficulty staying awake
☐	Excessive	☐	Choking	☐	Problems staying	☐	Waking up afraid/can't
☐	Headaches	☐	Gasping	☐	Unusual behavior	☐	Sudden weakness
☐	Night Sweats	☐	Coughing	☐	Irregular	☐	Sleep
☐	Waking fast heart			☐	Leg movements,	☐	kicks

What is your usual sleep position? Supine ☐ Prone ☐ Left Side ☐ Right Side ☐

What is your usual sleep/wake time? _____

Do you nap during the day/night? Yes ☐ No ☐ If yes, how long and how often? _____

Medical History - Please specify:

Circle all that apply:

- Cardiac Issues: Irregular heart beat, arrhythmias heart attack, stroke, hypertension, chest pain, pace maker, heart surgery, or cardio version.
- Respiratory Issues: COPD, emphysema, asthma, bronchitis, TB, or shortness of breath
- Any planned medical procedures? Yes ☐ No ☐ If yes, please explain:
  _____
- Are you experiencing any pain? Yes ☐ No ☐ If yes, please explain:
  _____
- Do you have any allergies? Yes ☐ No ☐ If yes, please explain:
  _____
- Have you had a previous sleep study? Yes ☐ No ☐ If yes, provide date:
- Are you currently or have you previously used PAP? Yes ☐ No ☐
- Do you use alcohol, tobacco, or other substances? Yes ☐ No ☐ If yes, please explain:
  _____

Medications: Prescriptions and Non-Prescriptions (over the counter)

_____

_____

_____

_____

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Patient Information

First Name: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Patient Overnight Stay Preparation Forms

1) Please fill out the other patient forms and present them to the technician upon arrival.
2) Please ensure you bring your photo ID and insurance card.
3) Bring a list of medications you are currently taking.
4) If you want you can bring water and a light snack, such as a granola bar that is acceptable.
5) Please plan to arrive between 8:00 - 9:00 PM **No Earlier than 8:00 PM**
6) Take the evening telephone number to the lab with you, should you need to communicate with the technician that evening (516) 873-6500.
7) Have a safe trip to our facility; we look forward to meeting you.

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