NEUROLOGY & SLEEP SPECIALISTS
an affiliate of Mountain View Hospital

View our website at sleepandneuroexperts.org
Please fill out in **BLACK** ink only

History Intake Form

Name: _____ **Date**: _____

Pharmacy: _____ **Primary Care Provider**: _____

Past Medical History: (Please check all that apply)

☐ None	☐ Colon Cancer
☐ Anxiety	☐ Lung Cancer
☐ Hepatitis	☐ COPD
☐ Arthritis	☐ Lymphoma
☐ Hypertension (High Blood Pressure)	☐ Coronary Artery Disease
☐ Asthma	☐ Prostate Cancer
☐ HIV/AIDS	☐ Depression
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ Radiation Treatment
☐ Hypercholesterolemia (High Cholesterol)	☐ Diabetes
☐ BPH (Benign Prostate hypertrophy)	☐ Seizure
☐ Hyperthyroidism (High Thyroid)	☐ End stage renal disease
☐ Bone Marrow Transplantation	☐ Stroke
☐ Hypothyroidism (Low thyroid)	☐ GERD (Gastro esophageal reflux disease)
☐ Breast Cancer	☐ Other:_____
☐ Leukemia	

Past Surgical History: (Please circle those that apply) None, Tonsillectomy, Hysterectomy, Gall Bladder, Appendix, Knee, Hip, Back, Shoulder

Other: _____

Social History

Marital Status: Married / Single / Divorced / Widowed **Children**: _____ **Pets:** _____

Work Status: Full time / Part time / Retired / Home Maker / Disabled

Smoking: Yes / No **Alcohol:** Yes / No / Rarely / Social / Occasionally / Daily **Any Illicit drug use:** Yes / No

Caffeine use: _____ **Diet**: _____ **Exercise**: _____

Family History of disease/illness:

Mother: _____ **Father**: _____

Siblings: _____ **Other**: _____

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Please check any items that currently pertain to your health:

☐ Snoring	☐ Trouble staying asleep
☐ Waking feeling unrested	☐ Memory problems
☐ Witnessed apneas/pauses in breathing	☐ Difficulty concentrating
☐ Excessive dry mouth upon awakening	☐ Restless legs
☐ Sore throat in the mornings	☐ Heart palpitations
☐ Sore/stiff neck upon awakening	☐ Waking up gasping for air
☐ Night time urination	☐ Bruxism (grinding of teeth/clenching)
☐ Trouble falling asleep	☐ Migraines/headaches

Please answer all questions below:
Time you go to bed: _____
How long it takes to fall asleep (in minutes):_____
How many times you wake up at night: _____
Number of minutes of awake time, each time: _____
Time you wake up in the morning: _____
How long it takes you to get out of bed: _____

Epworth Sleepiness Scale: Likelihood of dozing or falling asleep in the following situations:

Answer using: 0=Never 1=Slight 2=Moderate 3=High chance

Sitting and Reading:_____	Watching Television: _____
Sitting inactive in a public place (e.g., theater, meeting, dinner, event): ____	Passenger in car for over an hour without stopping for a break:_____
Lying down to rest when circumstances permit:____	Sitting talking to someone:_____
Sitting quietly after a meal w/o alcohol: ____	In a car while stopped for a few minutes:_____

_____/24 ESS ***If you score higher than 10 from above, then fill out the following:**

Swiss Narcolepsy Scale: Answer using: **1**=Never **2**=Rarely **3**=Sometimes **4**=Often **5**=Almost always

How often are you unable to fall asleep? _____
How often do you feel bad or not well rested in the a.m.?_____
How often do you nap during the day? _____
How often have you experienced weak knees or buckling of the knees during emotions such as laughing, happiness, or anger? _____
How often have you experienced sagging of the jaw during emotions such as laughing, happiness, or anger?_____

Name: _____

Please list all medications that you are currently taking, including nonprescription medications and herbal supplements. (Or supply a current list)

Medication Name:	Amount Taken:	Frequency:

Allergies: _____

Depression Screening

	Not at all	Several days	More than ½ days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep/staying asleep/sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating				
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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INTAKE

Name_____**Email**_____
First Middle Last

Address_____
Street City State Zip

Date of Birth_____ **Age** ____ **Sex** ____ **Race** _____ ***Hispanic/Latino/Spanish origin?*** **Yes/No**

Social Security # _____-____-_____**Ref Phys** _____ **Primary Care Phys** _____

Home/Preferred # _____ **Cell #**_____ **Other #**_____

Occupation _____ **Employer** _____

Spouse's Name_____ **DOB**_____ **Phone #** _____

INSURANCE

(A copy of your insurance cards are required to be presented on or prior to initial Date of Service)

Primary Insurance_____
Insurance Name Policy # Group #

Policy Holder_____
Name Relation SS# Date of Birth

Secondary Insurance_____
Insurance Name Policy # Group #

Policy Holder_____
Name Relation SS# Date of Birth

EMERGENCY CONTACTS

Emergency Contact #1 _____
Name relationship Date of birth Phone #

Emergency Contact #2 _____
Name relationship Date of birth Phone #

Patient Signature: _____ ***Date:*** _____

*By signing, I authorize staff at the Neurology & Sleep Specialists to contact the people above in the event of an emergency.

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PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of protected health information is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

☐ Cell Phone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Home Telephone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Work Telephone _____
- OK to leave message with detailed information
- Leave message with callback number only

☐ Written Communication
- OK to mail to home address
- OK to mail to my work address
- OK to fax to this number _____

☐ OK TO RELEASE INFORMATION TO:

- Name:_____ Relationship:_____ Phone#:_____
- Name:_____ Relationship:_____ Phone#:_____
- Name:_____ Relationship:_____ Phone#:_____

_____ _____

Patient Signature ***Date***

_____ _____

Print Name ***Date of Birth***

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Idaho Falls - 2680 Channing Way, Idaho Falls, ID 83404
Rexburg - 404 N. 2nd E, Rexburg, ID 83440
Blackfoot - 1443 Parkway Dr. Blackfoot, ID 83221

PAYMENT AND NO SHOW POLICIES:

Your copayment is due at the time of service. We will file your insurance claim, however, you are responsible for all charges regardless of your insurance coverage. If sent to collections, all collection agency fees and attorney fees will be incurred by the patient if not paid as agreed. We are an affiliate of Mountain View Hospital, and they handle our billing. The billing office phone number is (208) 557-2871.

We understand that unanticipated events happen in everyone's lives and we try to be understanding of this. However, it is our desire to be effective and fair to all patients. Please understand that other patients may be competing for your appointment time. In order to be courteous to them and our providers, we ask that you give a 24 hour notice of cancellation. As a new patient, if you "no show" your first appointment, YOU MAY NOT BE ABLE TO RESCHEDULE. When you have missed 3 appointments as an established patient, you may be discharged from our practice. If you miss an appointment or do not cancel 24 hours before a scheduled appointment (except for emergency situations), you will be charged a $50.00 no show fee, which is not covered by insurance.

If you arrive late, your appointment may be shortened in order to accommodate other scheduled appointments. Depending on how late you arrive, your provider may determine there is not enough time remaining to begin treatment, and you may need to reschedule.

I authorize the Sleep Specialists to release any information acquired in the course of my treatment to my insurance company. I also authorize payment directly to Mountain View Hospital for medical services.

_____ _____
PRINT NAME DATE OF BIRTH

_____ _____
SIGNATURE DATE

Patient Name: _____ D.O.B: _____ Date: _____

CLINIC CONDITIONS OF ADMISSION TO THE SLEEP SPECIALISTS
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1) MEDICAL AND SURGICAL CONSENT: I, the undersigned, consent to the services which may be performed during this outpatient visit, including office visit, which may include but are not limited to laboratory procedures, radiology procedures, diagnostic procedures, stress testing, rendered to me under the general and special instructions of my provider. This consent includes testing for blood-borne infectious diseases, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a provider orders such tests for diagnostic purposes. If the patient takes any medications or other substances without orders from the provider, the patient hereby releases the hospital and provider from liability for any reaction that may occur. In the event of an emergency, I authorize Mountain View Hospital (MVH) to transfer myself to another health care facility should my provider determine if necessary. In addition, I also consent to the release of my medical records to such facility.

2) RELEASE OF INFORMATION: I authorize the clinic and any provider involved in my care to release medical information and supporting documentation of same as compiled in my medical records during the outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care. If my injury is work-related, I authorize the clinic to release any information from my medical records to my employer and/ or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care. I acknowledge that patient medical records at the clinic are made available through computer networks to hospital personnel, providers involved in my care and their offices.

3) PATIENT PRIVACY I have read and/or received the information sheet entitled
"HIPAA NOTICE OF PRIVACY PRACTICES" available to me at www.mountainviewhospital.org

☐ YES I have received and/or had the opportunity to review MVH's "Notice of Privacy Practices" either in electronic or paper form. Any questions that I had were answered.

☐ NO I did not receive nor have had the opportunity to review MVH's "Notice of Privacy Practices".

4) PATIENT RIGHTS I understand that MVH has adopted an extensive Patient Rights Policy, which affords patients' rights to respect and foster the patient's dignity, autonomy, positive self-regard, civil rights and involvement in their case. These rights are posted throughout our hospital and clinics, available on our website, or available by asking the admissions desk for the Patient's Rights pamphlet.

5) WEAPONS/EXPLOSIVES/DRUGS: I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, or illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

6) FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS: In consideration of clinic services rendered, I hereby authorize payment directly to the above named clinic for benefits otherwise payable to me, but not to exceed the clinic's regular charges. In addition, I authorize payment of Medicare/Medicaid/Insurance benefits to any contracted provider; this includes, but is not limited to laboratory procedures, radiology procedures, and anesthesia, pathology, or hospital services rendered to me under the general and special instructions of my provider during this encounter. I understand that I am financially responsible for charges not covered by my plan. In the event that this account is not paid according to the terms of the clinic's credit policy, I agree to pay interest at the rate of 18% APR and/or costs of collection, not to exceed reasonable legal fees and court costs. If my account is assigned to a collection agency for collection and suit is filed to recover payment I agree to pay as a reasonable attorney's fee 33% of the principal and interest on my account balance, or any sums awarded by the court, whichever is greater, I further agree to pay reasonable cost of suit.

7) MEDICARE PATIENT CERTIFICATION: I certify that the information given by me in applying for payment under Title XVII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

8) MOUNTAIN VIEW HOSPITAL IS A PHYSICIAN OWNED HOSPITAL: Upon request a List of Ownership will be provided to you.

☐ Acknowledged

I hereby certify and state that I have read, and that I fully and completely understand the Conditions of Admission and Authorization for Medical Treatment, and that I have signed the Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurance, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

☐ Patient is medically unable to sign the Conditions of Admission

_____ _____
Patient/Parent/Guardian/Conservator If other than patient, indicate relationship

_____ _____ _____
Print Name Date Witness