Please arrive a few minutes before your appointment. It is important that you bring your 
**photo ID, insurance cards, and completed paperwork.** We collect all co-pays, co-
insurances, and deductibles at the time of service. Please call prior to your appointment if 
you need to make financial arrangements.

Please fill out the enclosed patient registration forms and bring these with you on the day 
of your appointment.

It is very important that you bring the following:
- All medications (including eye or ear drops, creams, and inhalers).
- Bring your CPAP machine
- Records from your referring physician.
- Insurance cards and photo ID
- **Completed patient registration forms.**

Please call within 48 hours if you are unable to keep this appointment! If you do not 
call to cancel or re-schedule your appointment, you will be billed a $50.00 no show 
fee. Same day cancellation will be billed a $50.00 same day cancellation fee.

We look forward to seeing you!

Athens Pulmonary and Sleep Medicine, P.C. 
706-549-5560
We are located in the physician offices within Ty Cobb Regional Medical Center. Athens Pulmonary and Sleep Medicine is located in Suite 1008.
Please read each line below and sign to acknowledge that you have read and understand our payment policy regarding patient responsibility.

Financial Responsibility

For patients with no insurance coverage, payment is due at time of service. As a self paying patient you will receive a discounted rate on your visit as long as the payment is made in full on the date of service. If other arrangements have to be made, the office visit will not be discounted. Please call the office prior to your appointment to discuss the financials of your appointment. We accept cash, checks, and all Visa or Master cards. If you need further assistance please call 706-549-5560 prior to your visit.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit. All services not paid by your insurance company will become your responsibility. It is the patient’s responsibility to check their own insurance benefits and coverage. If for any reason your insurance company becomes insolvent, any balance is the patient’s responsibility.

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine or non-covered, or “deemed medically unnecessary” by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient’s responsibility to notify us of any change in insurance, mailing address, or contact information.

Cancellation Policy and No Show Policy

It is your responsibility to call within 24 hours of your scheduled appointment time if you need to reschedule your appointment. If you have not called within 24 hours of your appointment or you are a No Show for your appointment, you will be charged a $25 Cancellation/No Show fee. New Patient appointments have a $50 charge for No Show/same day cancellations.

I acknowledge that I have read and understand the above information.

Patient Signature: ___________________________ Date: ___________________________
I agree that I have been given the opportunity to read and/or receive a copy of Athens Pulmonary Notice of Privacy Practice.

**Release of Information:** Athens Pulmonary may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to Athens Pulmonary for reimbursement for services rendered and (2) any health care provider for continued patient care. Athens Pulmonary may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
AND PRIVACY PRACTICES ACKNOWLEDGEMENT

I give my authorization to use or disclose my protected health information to any health care provider who is involved with my medical treatment or services, my health insurance plan and/or medical billing clearing house who is involved with my insurance claims fulfillment.

I authorize you to release information to the following people:

Name __________________________ Phone __________________

Relation __________________________

What specific information to disclose __________________________

Name __________________________ Phone __________________

Relation __________________________

What specific information to disclose __________________________

I authorize the office to contact me in the following manner:

___ Home Phone

___ Leave detailed information

___ Leave call back number only

___ Work Phone

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates who are part of the health care process. These business associates will also keep your health information confidential. I also have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name __________________________ Date of Birth ____________

Signature __________________________ Date ____________
PATIENT REGISTRATION

Patient Name: ___________________________ Date Of Birth: ______________________

SS#: ________________________________

Circle One: MALE/FEMALE  Marital Status: S/ M /W /SEP/ DIV

Street Address: ___________________________ City: ___________________________

State: ______________ Zip Code: ______________ Email: ___________________________

Telephone Number: (Home) ___________________________ (Cell) : ___________________________ (Work): ___________________________

What is the BEST way to contact you? ______________________________________

Emergency Contact: ___________________________ Relationship: __________ DOB ___________________________

Contact Tel#: ___________________________

PATIENT EMPLOYER INFORMATION

Employer Name: ___________________________ Telephone #: ___________________________

Employer Address: ___________________________ City/State: ___________________________ Zip: ______________

Patient’s Occupation: ___________________________

INSURED PERSON (IF NOT PATIENT)

Name: ___________________________ Telephone Number: ___________________________

Street Address: ___________________________ City/State: ___________________________ Zip: ______________

INSURANCE

Primary Ins. Co. Name: ___________________________

ID#: ___________________________ Group#: ___________________________ Phone #: ___________________________

Secondary Ins. Co. Name: ___________________________

ID#: ___________________________ Group#: ___________________________ Phone #: ___________________________

Additional Information

Referring Doctor: ___________________________ Primary Care Doctor: ___________________________
IF YOU ARE CURRENTLY EXPERIENCING EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH A SLEEP DISORDER, REMEMBER, SLEEPINESS AND FATIGUE CAN IMPAIR YOUR ABILITY TO SAFELY DRIVE AN AUTOMOBILE OR OPERATE CERTAIN EQUIPMENT. FOR YOUR SAFETY AND THE SAFETY OF OTHERS, YOU SHOULD REFRAIN FROM DRIVING OR OPERATING DANGEROUS EQUIPMENT UNTIL YOU ARE SURE YOUR SLEEPINESS IS UNDER CONTROL. IF YOU HAVE CONCERNS ABOUT YOUR LEVEL OF DAYTIME SLEEPINESS, DISCUSS THESE CONCERNS WITH YOUR PHYSICIAN.

After you start driving again, please remember the following:

1. Do not drive alone for a long period of time.
2. Drive only when most alert and stop frequently to refresh yourself.
3. Do not push yourself beyond your limits. Do not drive if you cannot keep your eyes open.

I have been instructed and understand:

1. The dangers of driving and operating dangerous equipment with severe fatigue or sleepiness.
2. I should not drive or operate dangerous equipment until my sleepiness is under control.

_________________________  ________________________
Patient Signature          Date

_________________________  ________________________
Witness                    Date
Date: ___________________________   Name: ___________________________

HEIGHT: _______   WEIGHT: _______   COLLAR SIZE (MEN ONLY): _______

What brings you here to see us? (CHECK ALL THAT APPLY)

_______ Excessive daytime sleepiness
_______ Snoring
_______ Insomnia
_______ Leg restlessness
_______ Irregular breathing during sleep
_______ Other. Specify: _____________________________________________

THE EPWORTH SLEEPINESS SCALE
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would effect you. Use the following scale to choose the most appropriate number for each situation:

FOR EACH ONE, EITHER PUT 0, 1, 2, OR 3

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>2. Watching TV</td>
<td></td>
</tr>
<tr>
<td>3. Sitting inactive in a public place (theater or a meeting)</td>
<td></td>
</tr>
<tr>
<td>4. As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>5. Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>6. Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>7. Sitting quietly after a lunch without alcohol</td>
<td></td>
</tr>
<tr>
<td>8. In a car while stopped for a few minutes in traffic</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>
**Patient History**

**How often do you:**

<table>
<thead>
<tr>
<th><strong>Symptom</strong></th>
<th><strong>CIRCLE ONE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>*Have trouble at school/work due to sleepiness</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Snore Loudly enough that others complain</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Told you stop breathing during sleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Awaken yourself snorting</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Awaken feeling short of breath or chocked</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Awaken with a headache</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Awaken feeling as tired as when you went to bed</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Have nightmares</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Act out your dreams while asleep (swing arms or yell)</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Sleepwalk</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Talk in your sleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Wake panicked with heart pounding or beating irregularly</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Grind teeth during sleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Have restless/aching feeling in your legs that makes you want to move them</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Take more than 15 minutes to fall asleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Wake several times during the night and can't get back to sleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Have thoughts racing while trying to sleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Feel physically weak or buckle at the knees when mad, sad, happy (or after burst of emotion)</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Feel unable to move (paralyzed) when waking/falling asleep</td>
<td>never/sometimes/frequently</td>
</tr>
<tr>
<td>*Experience &quot;hallucinations&quot; when awakening or falling asleep (see other people in room, hear voices, etc.)</td>
<td>never/sometimes/frequently</td>
</tr>
</tbody>
</table>