Directions to Sleep Unlimited, Inc.
320 Walnut Bend Suite 6
Cordova, TN 38018
901-737-9196/ fax: 901-432-6230
sleepunimited@willwork4sleep.com

FROM I-240 –(BARTLETT) Take Germantown Exit, go South on Germantown Parkway. Continue down Germantown through Walnut Grove, past the Agri-Center. The first light past the Agri-Center (on your right) will be Walnut Bend (at the Cirkle K gas station), take a left at that light. You will pass a day care center on the right. We are located in the first brick building past the gas station on the right (THE BEND). Suite 6. Our Suite is in the center of the first building. You may see LOWES behind our building. You will have to pass the building to get into the entrance to the parking lot.

From Germantown – Go North on Germantown Parkway. Continue past LOWE's on the right side, the light at circle K gas station is Walnut Bend, take a right at that light. We are located in the first brick building past the gas station on the right (THE BEND). Suite 6. Our Suite is in the center of the first building. You may see LOWES behind our building. You will have to pass the building to get into the entrance to the parking lot.

What to Bring – If you have any questions or special needs please feel free to call us or email us at the above number. Please bring your insurance cards and a form of ID. Bring something comfortable to sleep in (T-shirt and shorts or sweats is always a good choice). You must sleep in something more than your underwear. You are welcome to bring your own pillow, blankets, ect… You may also bring laptop or IPAD (we have wireless internet access for your convenience). Please bring any toiletry items to freshen up as well as any medications that you may be taking.
You are welcome to bring any snacks if you desire.

If you currently use CPAP, bring your mask with you so you can show technician what you are currently using. We look forward to seeing you soon.

Instructions for Test – On the day of your test: You may have your morning coffee or caffeine drink, but after that do not drink or eat anything that has caffeine (ie.. Coke, Chocolate) do not take any naps and come with a clean,

dry head of hair (if you have a weave or extensions – please remove before the study). Eat a good meal before you come in. Bring all medications that you would normal take with you. If you take a sleep aid, please bring with you as well. Also, let us know if you have a special diet or any special concerns.

Your test is scheduled for 8:30pm. Unless prior arrangements have been made. The technician does not get to the lab till then. **Your study will be completed around 6am, therefore if you have to make arrangements for transportation, please inform the technician.**

TO AVOID CANCELLATION FEE OF $250.00, PLEASE CANCEL APPOINTMENTS NO LATER THAN 48 HOURS PRIOT TO TEST.

If you have any questions regarding your study you may visit our website at www.willwork4sleep.com or contact us at the above number.

BILLING INFORMATION

(IMPORTANT INFORMATION PLEASE READ)

As a courtesy, **Sleep Unlimited, verifies your benefits with your insurance company**. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of Sleep Unlimited that payment of **copays are due at the time of service**. You will be informed at the time of scheduling if you have a copay due. Copays may be paid by cash, check or credit card. If you would like to pay by credit card, you may pay over the phone to our home office (901-758-2838).

If you are covered by health insurance with Sleep Benefits, we will bill your insurance. Please provide your insurance information at the time of your visit if we do not already have it. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan**. If your insurance company mails the payment directly to you**, and it is not forwarded to Sleep Unlimited, you will be turned over to a collection company. In the event you are turned over to collection for not forwarding funds, you will be turned over for the full amount of the study.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services at the in-network rates. Please remember that you are 100% responsible for all charges incurred: your **physician's referral and our verification of your insurance benefits are not a guarantee of payment by your insurance company**.
We highly recommend you also contact your insurance carrier and **check into your coverage for Sleep Management.** Do not assume that you will not owe anything if you have more than one insurance policy.

We make every effort to ensure that your out of pocket costs will not be more than any other sleep facility. If you have any questions regarding your insurance benefits, what your out of pocket costs will be, or to set up payment arrangements; please feel free to contact our billing department at 901-758-2838.

Please fill out the following paperwork and return via email or fax prior to your study. Or you may bring it in with you to your study as well.

Patient Information Sheet

Patient Name: _____ Today's Date: _____
SS #: _____ Age: _____ Date of Birth: _____
Home Address: _____
_____

Email Address: _____
(may we use this email address to contact you regarding scheduling, results, and billing? _____)
Patients Employer: _____
Occupation: _____

Referring Physician: _____
Chief Complaint: _____

Day (work) Phone: _____ Evening (home) Phone: _____
Cell Phone: _____
Spouse: _____ Employer: _____
Date of Birth: _____ Phone Number: _____

May we leave a message for your on your home or work number? _____
In the event that we are unable to reach you, with whom may we discuss your scheduling, results, and treatment?
Name: _____ Phone Number: _____

Primary Insurance Information

Insurance Company _____
Address: _____
Telephone: _____ Contact: _____
Primary Insured: _____ Insured's Date of Birth: _____
ID# _____Group/Policy#_____ Deductible: _____

Secondary Insurance Information

Insurance Company _____
Address: _____
Telephone: _____ Contact: _____
Primary Insured: _____ Insured's Date of Birth: _____
ID# _____Group/Policy#_____ Deductible: _____

Ame 10/05/12

Sleep Unlimited, Inc.- Sleep Disorders History and Physical		
FIRST NAME:	**MIDDLE:**	**LAST:**
Date of Birth _____ / _____ / _____ Age: _____	Date of Visit _____ / _____ / _____	
Referring M.D.	Primary M.D.	
Marital Status ☐ Single ☐ Married ☐ Divorced	Employment:	Handedness ☐ Right ☐ Left

Chief Complaint: Please briefly state in your own words the reason you are here for a sleep evaluation

For all sections below: **A check in the box denotes a "yes" to the described symptom; if "no", then do not check. Where applicable circle "Y" for yes or "N" for no.**

Sleep Symptoms:			
☐ Snoring	☐ Light	☐ Moderate	☐ Loud
☐ Snoring is so bad that spouse/bed partner sleeps in another room			
☐ Observed breathing pauses		☐ Awakenings from snoring	
☐ Sleep-related reflux (heartburn)		☐ Awakenings gasping for breath	
☐ Sinus congestion during sleep		☐ Kick legs during sleep	
☐ Sensations in legs make it difficult to fall asleep		☐ Breath through mouth/open mouth during sleep	
☐ Prominent sweating of upper chest & back during sleep			
☐ Morning headaches- if so how often?			

Sleep Habits: All times/numbers are average, can give range (Ex: 9-10 pm, etc.), no need to be overly exact.		
Bedtime (time to get in bed with the intention of falling asleep):		
Last time wake-up:	Use an alarm: Y ☐ N ☐	
# awakenings during sleep period:	Most common reason:	
Once you decide you want to fall asleep, how long does it take?		
Estimated average hours sleep per night:	# naps per week:	Avg. duration:
If it takes greater than 30 minutes to fall asleep, what is the main reason? (Check below)		
☐ Racing thoughts ☐ Heartburn ☐ Planning out day's events	☐ Heartburn ☐ Spouse ☐ Breathing/snoring/snorting	☐ Pain ☐ Restless legs

Other:			
Do you watch TV in bed? Y ☐ N ☐		Do you read in bed? Y ☐ N ☐	
Do you watch the clock? Y ☐ N ☐		Is your bedroom quiet? Y ☐ N ☐	
Is your bedroom dark? Y ☐ N ☐			
Do you turn on the light when you get up? Y ☐ N ☐		Average time of evening meal:	
Primary Sleeping position:	☐ Supine (back)	☐ Lateral (side)	☐ Prone (on front)

Parasomnias / Seizures / Narcolepsy/RLS:			
☐ Sleep walking	☐ Sleep talking	☐ Sleep eating behavior	
☐ Act out dreams (particularly with violent imagery of fighting, etc.) with striking wall, table, bed partner, etc.			
☐ Seizures during sleep		☐ Awaken having bitten tongue	
☐ Dream-like hallucinations upon falling and or awakening from sleep			
☐ Sudden weakness and onset of sleepiness upon laughing, being startled, or extreme emotions			
☐ Do your have discomfort or bothersome sensations in your legs when inactive (Ex: passenger in the car, watching TV, relaxing before bedtime).			
Check appropriate description	☐ Burning ☐ Crawling	☐ Numb ☐ Jumping	☐ Ache ☐ Nervous
☐ Is the discomfort relieved by movement		☐ Does the sensation prolong sleep onset	
☐ Do you kick your legs during sleep		☐	

Past Medical History: Please check all *non-surgical* medical diagnoses that you have been given		
☐ None	☐ Hypertension	☐ Strokes
☐ Diabetes	☐ Heart attacks	☐ Rheumatoid arthritis
☐ Fibromyalgia	☐ Depression	☐ Liver disease
☐ Osteoarthritis	☐ High cholesterol	☐ Migraine headaches
☐ Epilepsy	☐ Parkinson's disease	☐ Gastroesophageal reflux
☐ Traumatic brain injury	☐ Cerebral aneurysm	☐ Brain tumor
☐ Meningitis	☐ Lupus	☐ Dementia
☐ Please list others:		

Past Surgical History (please write approximate year surgery was done)		
☐ Appendix removed	☐ Gall bladder removed	☐ Coronary bypass grafts
☐ Coronary stents	☐ Artery stents in legs	☐ Hernia repair
☐ Breast cancer	☐ Hiatal hernia repair	☐ Hysterectomy
☐ Tubal ligation	☐ Brain surgery	☐ Carpal tunnel
☐ Vertebral disc surgery	☐ Spinal fusion	☐ Brain (VP) shunt
Other (please list):		

Allergies- This is specific to food and drug allergies (not pollen, etc.). Please list type of reaction (i.e., rash, etc.).

Family History- List blood relatives with current health status and any illnesses they have had or have.					
Blood relative	Health Status	Present age	Age at death	Cause of death	Illnesses
Father					
Mother					
Brother					
Sister					
Children					

Social History				
☐ Single		☐ Married	☐ Divorced	☐ Widowed
# Daughters		Ages	#Sons	Ages
Occupation				
❑ Exercise (describe)				
Alcohol	☐ Never	☐ Beer #___ per d/w/mo.	☐ Wine #___ per d/w/mo.	☐ Liquor #___ per d/w/mo.
Smoking	☐ Never	#Packs per day	How many years?	Discontinued? Y ☐ N ☐
Caffeine	☐ Never	# Coffee per day	#Colas per day	#Tea per day
Illicit drugs	☐ Cocaine	☐ IV	☐ Marijuana	☐ Amphetamines

MEDICATIONS:

EPWORTH SLEEPINESS SCALE

Name:_____

Today's date:_____ Your age:_____

Height:_____ Weight:_____

Your sex (male = M; female = F):_____

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 have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit.	_____
Sitting and talking to someone .	_____
Sitting quietly after a lunch without alcohol..	_____
In a car, while stopped for a few minutes in traffic.	_____

Total: