DRS. GIRGIS & ASSOCIATES

Breathe Better, Hear Better, Sleep Better

TODAY'S DATE _____/_____/_____ AGE: _____ MARITAL STATUS: (S M W D)

DATE OF BIRTH:_____/_____/_____ SOCIAL SECURITY #: _____ GENDER: (Male / Female)

PATIENT NAME: _____ NICKNAME: _____

PREFERRED LANGUAGE: _____ RACE: _____ (_____ Decline To Specify)

ETHNICITY: _____ (_____ Decline To Specify)

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Street City State Zip

EMERGENCY CONTCT: _____ PHONE: _____ RELATION: _____

PHARMACY: _____ PHARMACY PHONE; _____
Name & Address or Location

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE: _____
Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY MEDICAL INSURANCE: _____
Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: _____/_____/_____

POLICY NUMBER: _____ GROUP NUMBER: _____

HOW DID YOU HEAR ABOUT US?

_____PHYSICIAN (Name: _____) _____FAMILY/FRIEND (Name: _____)

_____INSURANCE (Name: _____) _____MAILER(Audiology) _____MAGAZINE (Suburban Living)

_____NEWSPAPER(Hinsdalean/OakParkLeaves/Doings/Pioneer _____DEX/YELP _____ZocDoc _____GOOGLE _____WEBSITE

_____HOSPITAL (NAME: _____) _____FORMER PATIENT

In consideration of these medical services rendered by Drs. Girgis & Associates, S.C., and the treating physician(s) I hereby assign any medical reimbursement to Drs. Girgis & Associates, S.C., and the treating physician(s).**I authorize the release of any medical information in my medical records necessary to process any insurance claim.** I understand that any fees for services rendered are my responsibility. If I am a participant in an insurance plan which requires a referral from my primary care physician and I do not have that written referral or referral number, all fees for services rendered will be my responsibility. If my health insurance policy is not in force at the time of the service, I accept full responsibility for all fees. **I authorize the release of any part of my medical record to other physicians and facilities which are participating in my care.**

_____

Patient/Responsible Party Signature Date

Drs. Girgis & Associates, S.C. **pt acct #_____**
Financial Policy

We would like to thank you for choosing Dr. Girgis & Associates, S.C. as your medical provider. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment.

Cancelled Appointments
If you are unable to keep your appointment, please call our office within 24 hours to reschedule it. This will enable us to offer your time slot to another patient. You will also receive additional information on cancellation policies for procedures and testing in our office.

Patients Without Insurance
Full payment is expected at the time of service for office visits with the providers or audiologists and for any testing or procedures done during your visit.

Insurance
It is your responsibility to be aware of your own coverage and to ensure that your insurance is in network with our practice. If your plan is out of network, you will be expected to pay in full for your visit at the time services are rendered. We do not bill insurances that are out of network. You will be financially responsible for any services not authorized by your insurance.

If your insurance requires a referral from your primary care doctor, it is your responsibility to obtain this prior to your appointment with our providers. If you do not have this, we may reschedule your appointment.

You will be asked to present your insurance card at every visit. This is to ensure that we have your correct insurance information so that we can properly bill the visit.

Co-payments
If your plan has a co-payment, it is your responsibility to inform the front desk staff. You will be expected to pay your co-payment at check-in. We are required under agreement with your insurance to collect this co-payment from you. A $10 service charge will be assessed each time a co-pay is not paid at the time of service. This fee will also be charged if the front desk is not made aware that your plan has a co-payment.

Patient Responsibilities
In the event that your insurance has paid its portion and a balance remaining is your financial responsibility, we expect prompt payment of any co-insurance, deductibles or any other moneys due. You will be billed for any co-insurance and deductibles. We are required under our contract with your insurance to collect this money from you. All balances are to be paid in full prior to the time of your visit. Please be aware that some of the treatments or tests performed may not be covered by your insurance and may not be considered by your insurance to be reasonable and medically necessary. We will remind you of these balances when confirming your appointment so that you can be prepared to pay them when you arrive at your appointment time. If your account becomes delinquent, Drs Girgis & Associates SC reserves the right to dismiss you from the practice. If you wish to remain a patient thereafter, we will keep a copy of your credit card on file so that we may charge any future outstanding balances.

Collections
Should it become necessary for us to turn your delinquent account over to a collection agency to collect the amounts owed us under the terms of your insurance coverage, you will be held responsible for any collection agency fees and/or attorney fees which will be 25% more than the actual charges for services rendered to you in our office. Further information that is helpful or necessary for collection purposes will be forwarded to our professional collection agency.

Workmen's Compensation
If your injury is due to an accident at your work place, please be sure to contact your employer and inform them of your injury. Failure to do so may result in your claim being denied. We will need prior authorization in order to make an appointment for you. Please be prepared to give all proper information when asked, so that we can get authorization from your workmen's comp case manager. This way we will be able to bill your claim to the proper insurance company. Please bring your own insurance card to the appointment so that we can make a copy. Should workmen's comp no longer authorize visits, you will be responsible to pay at the time of service for any office visits, procedures or tests that are ordered. If the workmen's comp case goes into litigation you will be held liable for any unpaid services. If payment is not made in a timely manner your balance will be transferred to our collection agency.

Secondary and Supplemental Insurance
We will file to your secondary insurance, but be aware that not all secondary policies cover left-over balances from the primary insurance. You will be held responsible for the charges. If a co-payment is involved we will expect payment at the time of service even if you have two policies. Certain retirement plans have benefits which are based upon a complex set of patient responsibility criteria. With this type of plan, you may be responsible for a deductible and out-of-pocket maximum, over and above Medicare deductibles, before your plan will actually begin to pay benefits.

Medical Forms and Records
There is a charge of $15.00 - $35.00 for the completion of any medical forms, depending upon the number of pages and complexity of the information requested. Payment is due at the time you pick up the forms. Please allow 5-7 days to complete them. If you would like them mailed to you or to your insurance company, payment will be due prior to mailing. If you request a copy of your medical records, there will be a charge based upon the number of pages that are printed or copied. Payment for medical records will also be required prior to release.

Assignment of Benefits and Medical Records Release
I hereby authorize my insurance benefits to be paid directly to the physician signed above, realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

I have read the Financial Policy and understand and agree to adhere to this policy. **X**_____

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.

Hinsdale Sleep Center
Breathe Better, Hear Better, Sleep Better
908 N. Elm Street, Hinsdale, Illinois 60521
Telephone: 630-528-9999 Fax: 630-427-6525

Patient Sleep Questionnaire

Demographics

Patient Name: _____ Date: _____ Patient ID: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Gender: _____

Marital Status: (S M W D) Occupation: _____

Sleep Complaint

1. Briefly describe your sleep complaint: _____

   _____

Sleep Schedule

2. What is your normal bedtime? _____
3. What is your normal wake time? _____
4. How long does it take you to fall asleep? _____
5. How many times do you wake up throughout the night? _____
6. How often do you usually nap? ☐ Never ☐ Little ☐ Weekly ☐ 2-3 times/wk ☐ Daily

Social History

7. How often do you usually exercise? ☐ Never ☐ Little ☐ Weekly ☐ 2-3 times/wk ☐ Daily
8. Do you smoke cigarettes *or* have you smoked in the past? ☐ Yes ☐ No

If Yes: How long have you smoked? _____ (Indicate in years or months)

How much do you smoke per day? _____ (Indicate cigarettes or packs)

If you quit, when did you stop? _____ (Indicate in years or months)

9. Do you drink alcohol? ☐ Yes ☐ No

If Yes, indicate at what time(s) and how much? _____

10. Do you drink anything with caffeine regularly? ☐ Yes ☐ No *(This includes coffee, tea, pop, energy drinks)*

If Yes, indicate type and at what time(s) throughout the day: _____

Medical History

11. Please list all current and/or past diagnoses: _____

_____

_____

12. Please list all current and/or past medications: _____

_____

_____

_____

13. Please list any allergies: _____

_____

14. Have you undergone upper airway or sinus surgeries? □ Yes □ No

If Yes, please describe any surgeries performed on the nose, mouth, throat, neck or head: _____

_____

15. Does anyone in your family snore or have any sleep conditions? □ Yes □ No

If Yes, please indicate, and their relationship to you (e.g. mother, father, brother, etc.): _____

_____

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits. For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work all day/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score.

Epworth Sleepiness Scale

16. *Check box with most appropriate answer:*

Please indicate how likely you are to fall asleep in each situation	**No Chance (0)**	**Slight Chance (1)**	**Moderate Chance (2)**	**High Chance (3)**
17. Sitting and Reading				
18. Watching TV				
19. Sitting inactive in a public place (e.g. theater, meeting)				
20. As a passenger in a car for an hour with a break				
21. Lying down to rest in the afternoon when circumstances permit				
22. Sitting and talking to someone				
23. Sitting quietly after lunch without alcohol				
24. In a car, while stopped for a few minutes in traffic				

_____ _____

Patient Signature **Date**

_____ _____

Hinsdale Sleep Center Staff Signature **Date**

25. How many hours of sleep do you typically get per night? _____

26. When do you usually feel at your best? □ Morning □ Evening
27. Does you sleep schedule change during weekends? □ Yes □ No

If Yes, indicate weekend bed and wake time? _____

Total score categories:

0-7 = *No clinically significant insomnia*
8-14 = *Subthreshold insomnia*
15-21 = *Clinical insomnia (moderate severity)*
22-28 = *Clinical insomnia (severe)*

Other Comments

Please describe any other information you feel may affect your sleep or treatment with us: _____

_____

_____

_____

_____