Reservation and No-Show Policy 2/1/2024

You must text 828-962-1850 or 828-962-4432 no less than 24 hours prior to your appointment to cancel to avoid being charged a no-show fee.

1. With your first no-show, a no-show fee of $100.00 payable by cash or check only will be due immediately to Piedmont Sleep Center. Payments must be mailed to 1070 Lenoir Rhyne Blvd SE Hickory NC 28602. Once received you will be eligible to be scheduled again.
2. With your second no-show a $200.00 fee payable by cash or check only will be due immediately to Piedmont Sleep Center. Payments must be mailed to 1070 Lenoir Rhyne Blvd SE Hickory NC 28602. You will then have to schedule a consult with Lake Norman Pulmonary and Sleep to discuss your conditions and the importance of treating sleep apnea as it relates to heart attack, stroke, and fatigue before you will be eligible to be scheduled.

Thank you,

Piedmont Sleep Center

Patient printed name___________________________________ Date __________

Patient signature ______________________________________ Date __________

Dr. Sever Surdulescu, Medical Director (Lake Norman Pulmonary & Critical Care Spec.)

Board Certified in Sleep Medicine

H

1070 Lenoir Rhyne Blvd. SE
Hickory, NC. 28602
(Lower Level of Eye Care Center)
Phone: (828) 322-3111
Fax: (828) 322-3160

L

302 Mulberry St. SW
Lenoir, NC. 28645
(Down From Caldwell Memorial)
Phone: (828) 322-3111
Fax: (828) 322-3160

M

123 Wamsutta Mill Rd Suite B
Morganton, NC. 28655
Phone: (828) 322-3111
Fax: (828) 322-3160
Behind Tractor Supply at Freedom Square Condos, second to last one on the right side.

PLEASE READ AND GO TO CIRCLED LOCATION

NAME___________________________

APPT. DATE_______________________

ARRIVAL__________________________

WAKE-UP_________________________

INSTRUCTIONS FOR ALL-NIGHT SLEEP STUDIES:

1. PLEASE RING DOOR BELL WHEN YOU ARRIVE.
2. PLEASE HAVE CLEAN HAIR, NO LOTION, NO MAKEUP.
3. BRING A LIST OF PRESCRIBED MEDS THAT YOU ARE TAKING. TAKE ALL YOUR PRESCRIBED MEDS AS NORMAL. DO NOT TAKE ANY "OVER THE COUNTER" DRUGS, ESPECIALLY ALLERGY OR COLD REMEDIES. YOU MAY TAKE TYLENOL OR ADVIL.
4. PLEASE BRING AN UPDATED INSURANCE CARD.
5. IF YOU HAVE A COPAY, PLEASE BRING CASH OR CHECK. (PLEASE MAKE CHECKS PAYABLE TO: LAKE NORMAN PULMONARY AND SLEEP PA).
6. NO ALCOHOL OR CAFFEINE.
7. DO NOT NAP.
8. WEAR PAJAMAS OR SHORTS AND A T-SHIRT. YOU MAY BRING YOUR OWN PILLOW.
9. FRIENDS OR FAMILY MAY NOT REMAIN IN LAB DURING STUDY. UNLESS THE PATIENT IS A MINOR. THEN AN ADULT THAT IS RESPONSIBLE FOR THE PATIENT MUST STAY.
10. PLEASE LET US KNOW BEFORE HAND IF YOU NEED SPECIAL ASSISTANCE.
11. DO NOT BRING A TV OR RADIO. CELL PHONE NEEDS TO BE TURNED OFF UPON ARRIVAL.
12. IF YOU USE A CPAP MACHINE AT HOME, PLEASE BRING YOUR MASK.
13. IF YOU ARE ON OXYGEN, PLEASE LET US KNOW AND BRING A CANNULA.
14. BRING THIS INFORMATION PACKET WITH YOU ON THE NIGHT OF STUDY.
15. INSURANCE BENEFITS ARE ESTIMATE ONLY, NO GUARANTEE OF EXACT AMOUNT.

***PLEASE UNDERSTAND THAT WE CAN NOT GIVE YOU ANY INFORMATION REGARDING YOUR SLEEP STUDY RESULTS.**

***If you are unable to keep your appointment, please let our office know within 48 HOURS so we can reschedule you. We only have 2 patients per night, and count on each one to show up to their scheduled appointment. If you are a no-show, you will not be rescheduled and charged $75.00 cancellation fee.**

***Insurance Benefits are estimates only and not a guarantee of payment.**

***You are responsible for providing the correct Insurance information. Please let us know if the information is correct and if you change your policies.**

***All home studies not returned 3 days from receipt of unit will be charged $25.00 fee per day unless arrangements have been made.**

Division of Lake Norman Sleep Center

Name: ___________________________

DOB: ____________________________

You're subject to Insurance plan and conditions.

No Guarantees per your Insurance company.

Use a pen for paper work.

All rough estimates are from your Insurance.

Lake Norman Pulmonary and Sleep / Piedmont Sleep Center

First name ________________________ **Middle Initial** _____ **Last name** ______________________________________

Date of Birth _____________ **Sex:** Male Female **Race:** Caucasian African American Hispanic Other

Ethnicity: Hispanic/Latino NON-Hispanic/Latino **Marital Status:** ____________

Social Security Number: ___________________ **Email Address:** ____

Address: ____ **City:** ____________________ **State:** _____ **Zip:** ___________

Home Phone: ______________________ **Cell Phone:** ______________________ **Work Phone:** _____________________

Employment Status: __________________ **Occupation:** ____

Employer: ____ **Employer Phone:** _____________________

Emergency Contact: **First Name:** ___________________________ **Last Name:** ___________________________________

Relationship to patient: _________________________________ **Phone Number:** __________________________________

Address: ____ **City:** ____________________ **State:** _____ **Zip:** ___________

Responsible Party: **First Name:** ___________________________ **Last Name:** ___________________________________

Relationship to patient: _________________________________ **Phone Number:** __________________________________

Address: ____ **City:** ____________________ **State:** _____ **Zip:** ___________

Primary Insurance Company: _________________________ **ID #:** ____________________________ **Group #:** _________

Insurance Address: __________________________________ **City:** __________________ **State:** _____ **Zip:** ___________

Insurance Company Phone Number: _________________________ **Policy Holder Name** __________________________

Policy Holder Address: ______________________________ **City:** __________________ **State:** _____ **Zip:** ___________

Policy Holder Phone: _________________________________ **Policy Holder Date of Birth:** __________________________

Policy Holder Relationship to Patient: ____

Secondary Insurance Company: ________________________ **ID #:** ___________________________ **Group #:** _________

Insurance Address: __________________________________ **City:** __________________ **State:** _____ **Zip:** ___________

Insurance Company Phone Number: _________________________ **Policy Holder Name** __________________________

Policy Holder Address: _____________________________ **City:** __________________ **State:** _____ **Zip:** ___________

Policy Holder Phone: ________________________________ **Policy Holder Date of Birth:** _________________________

Policy Holder Relationship to Patient: ____

Pharmacy Name: __________________________________ **Pharmacy Phone:** __________________________________

Address: _______________________________________ **City:** ___________________ **State:** _____ **Zip:** ___________

I authorize Lake Norman Pulmonary and Sleep / Piedmont Sleep Center to release my Protected Health Information including lab tests, x-rays, results, financial, and appointment information by phone, email, or text to the people listed below. I also understand that I have the right to revoke this authorization anytime.

Name: ____ **Relationship:** ______________________________

Name: ____ **Relationship:** ______________________________

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy policies. By signing, you agree that you have had the opportunity to read our Notice of Privacy Practices.

Signature: ____ **Date:** ______________

I hereby authorize Lake Norman Pulmonary and Sleep (LNPS) / Piedmont Sleep Center (PSC) to release any information acquired during my examination or treatment to the insurance company. I also authorize LNPS and PSC to file my medical claims to my insurance company on my behalf. I do understand that any cost that is given is strictly an estimate and there are no guarantees on the exact amount of the quote given. Should my insurance deny medical claims for such reasons as authorization, non-covered service, or deductible, I understand that I am fully responsible for my bill. I also must notify LNPS and PSC of any changes to my insurance coverage or contact information. I also authorize LNPS and PSC to obtain my medical history from my current and previous providers. This authorization shall remain valid until revoked in writing.

Signature: ____ **Date:** ______________

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Signature: ____ **Date:** _______________

Sleep Evaluation
Please circle all that apply to you.

Excessive daytime sleepiness	Waking with dry mouth	Difficulty falling asleep
Recent weight gain	Nighttime awakenings	Waking with headaches
Waking gasping for air	Waking to use the bathroom	Waking with a choking sensation
Depression	Nighttime hallucinations	Snoring
Awake but inability to move	Vivid dreams/nightmares	Restless leg
Leg movements/foot kick while sleeping		Observed pauses in breathing while sleeping

Do you feel like you get enough sleep?	Yes	No
Is your sleep environment quiet and dark?	Yes	No
Do you sleepwalk?	Yes	No
Do you talk in your sleep?	Yes	No
Do you sleep eat?	Yes	No
Do you nap?	Yes	No
Do you doze off at inappropriate times?	Yes	No
Do you ever fall asleep while doing a task?	Yes	No
Do you ever fall asleep while driving?	Yes	No
Do you have decreased work performance?	Yes	No
Do you have memory loss?	Yes	No
Do you feel like you have impaired judgement?	Yes	No

Bed time: __________ **Wake time:** _________

How do you feel upon waking? ____

How frequently do you exercise? ____

How has your mood been over the last month? (circle one)

Feel great, upbeat, optimistic	Fairly happy, feel good, things are going well
Somewhat down, discouraged, irritable, stressed	Fairly depressed, worried, irritable, angry

Sleepiness Scale

Please circle the most appropriate answer using the scale listed below.
0 – Would never **1 – Slight chance** **2 – Moderate chance** **3 – High chance**

How likely are you to doze off or fall asleep?

Sitting and reading	**0**	**1**	**2**	**3**	**Resting in the afternoon**	**0**	**1**	**2**	**3**
Watching television	**0**	**1**	**2**	**3**	**Sitting & talking to someone**	**0**	**1**	**2**	**3**
In a theater or meeting	**0**	**1**	**2**	**3**	**Sitting quietly after a meal**	**0**	**1**	**2**	**3**
Traveling as passenger	**0**	**1**	**2**	**3**	**Sitting in a stopped car**	**0**	**1**	**2**	**3**

Medical History

Do you have any history of the following (If you answer "yes" to any, please explain)

Lung problems **No** **Yes**____

Heart problems **No** **Yes**____

Diabetes **No** **Yes**____

Cancer **No** **Yes**____

High Blood Pressure **No** **Yes**____

Stroke **No** **Yes**____

Digestion/stomach problems **No** **Yes**____

Other Medical Conditions: ____

Are you currently or have you recently been experiencing any of the following? (circle all that apply)

Cough	Fever	Nausea	Headaches	Shortness of breath
Night sweats	Vomiting	Weakness	Wheezing	Chills
Diarrhea	Coughing up blood	Numbness	Weight gain	Weight loss
Fatigue	Tremors	Slurred speech	Sputum production	Abdominal pain
Chest pain	Skin rash	Back pain	Blood in urine	Palpitations
Skin lesion	Neck pain	Joint pain	Swelling	Painful urination
Urinary frequency	Increased thirst	Increased hunger	Heat intolerance	Cold intolerance
Sinus pressure	Vision changes	Hearing loss	Ringing in ears	Depression
Anxiety	Hallucinations	Sneezing	Itchy eyes	Nasal drainage

Please list any medications you are taking.

Medication name: ______________________________ **Dosage:** ____________ **Frequency:** __________

Medication name: ______________________________ **Dosage:** ____________ **Frequency:** __________

Medication name: ______________________________ **Dosage:** ____________ **Frequency:** __________

Medication name: ______________________________ **Dosage:** ____________ **Frequency:** __________

Please list any allergies to medications or food: ____

____

Surgical History

Please list and surgeries you have had:

____

____

____

____

Family Medical History

Please list any medical conditions or health problems.

Mother: ____

Father: ____

Grandparents: ____

Siblings: ____

Children: ____

Social History

Recent travel outside the USA: ____

Pets at home: ____

Hobbies: ____

Alcohol intake and frequency: ____

Caffeinated beverages per day: ____

Current smoker? Yes No When did you start? ______ **How much do you smoke?** __________________

Former smoker? Yes No How many years did you smoke and how much did you smoke? ____________

List any smokeless products you use: ____