Phone: (208) 523-7667 Fax: (208) 523-7668

2680 Channing Way Idaho Falls, ID 83404	1443 Parkway Dr Blackfoot, ID 83221	32 Madison Prof. Park, Ste. B Rexburg, ID 83440

Welcome to Dr. Talcott's Practice. We are looking forward to meeting you and would like to thank you for choosing us for all of your sleep needs.

Please make sure to bring your photo ID and insurance card(s) to your appointment. If your card(s) is not current, please contact your insurance company carrier to get all of the proper information. If you have MEDICAID as primary or secondary, you are responsible for getting a HEALTHY CONNECTIONS REFERRAL from your primary care doctor. If any of the insurance information is incorrect or missing, we will not be able to bill your insurance. Therefore, you will be responsible for the charges. Please be aware that co-pays are collected AT THE TIME OF SERVICE. If payment cannot be made, please contact Mountain View Patient Financial Services at (208) 557-2871.

We would also like to remind you that it is up to you to bring any and all previous lab work, previous sleep studies, or any other workups done prior to your appointment that you feel may be important to your visit. Please bring your machine with you if you currently have one. Thank you again for choosing us to help you with your sleep needs. If you have any questions or concerns regarding any of this information, please contact our office at (208) 523-7667.

Thank you!
The Sleep Specialists

Name:_____ DOB:_____ Date of Service:_____

Please check all items that apply in each category that currently pertain to your health

General:
- ☐ Unintended weight gain
- ☐ Unintended weight loss
- ☐ Fever
- ☐ Chills
- ☐ Tired
- ☐ Fatigued
- ☐ Sleep during the day
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Waking untested
- ☐ Shift work

Head:
- ☐ Migraines/headaches
- ☐ Loss of consciousness
- ☐ Sensation of spinning

Eyes:
- ☐ Itchy/watery
- ☐ Blurry vision
- ☐ Bags under eyes
- ☐ Loss of color vision
- ☐ CPAP causes irritation

Ears:
- ☐ Changed hearing
- ☐ Ringing in ears

Nose:
- ☐ Nose bleeds
- ☐ Stuffy/congestion
- ☐ Runny nose
- ☐ Sinus problems
- ☐ Loss of taste/smell

Mouth:
- ☐ Bleeding gums
- ☐ Use of dentures
- ☐ Sore throat in the morning
- ☐ Overbite
- ☐ Excessive dry mouth
- ☐ Difficulty swallowing
- ☐ Trouble speaking

Neck:
- ☐ Lumps in neck
- ☐ Stiff neck
- ☐ Sore neck when awakening

Lungs and airway:
- ☐ Shortness of breath with activity
- ☐ Wheezing
- ☐ Coughing
- ☐ Snorting/choking
- ☐ Nighttime awakening gasping for air
- ☐ Pausing in breath (witnessed)
- ☐ Snoring

Chest and Heart:
- ☐ Palpitations or fluttering
- ☐ Irregular heartbeat
- ☐ Crushing chest pain with activity
- ☐ Stabbing chest pain
- ☐ Seen a cardiologist since last visit

Abdomen:
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Change in appetite

Genito-urinary system:
- ☐ Frequent urination
- ☐ Hesitancy/dribbling
- ☐ Painful urination
- ☐ Nighttime urination
- ☐ Loss of bladder/bowel control
- ☐ Frequent infections
- ☐ Painful sex
- ☐ Decrease in sexual libido

Limbs:
- ☐ Use of cane, walker or wheelchair
- ☐ Limited range of motion
- ☐ Chronic muscle pain
- ☐ Pain that interferes with sleep
- ☐ Numbness, tingling, or weakness
- ☐ Fallen recently
- ☐ Swelling of feet/ankles
- ☐ Muscle cramps at night
- ☐ Restless leg or need to move
- ☐ Loss of muscle size
- ☐ Loss of coordination

Psychosocial:
- ☐ Mood changes
- ☐ Feeling emotionally numb
- ☐ Sad or depressed
- ☐ Anxious
- ☐ Mind racing at night

Neurological:
- ☐ Changes in handwriting
- ☐ Confusion
- ☐ Sleepwalking
- ☐ Seizures since last visit
- ☐ Confusion arousals at night
- ☐ Nightmare/terrors
- ☐ Tremors
- ☐ Acting out dreams
- ☐ Difficulty concentrating
- ☐ Memory problems

Endocrine:
- ☐ Excessive thirst or hunger
- ☐ Hot flashes or heat intolerance
- ☐ Chills or cold intolerance
- ☐ Night sweats

Skin:
- ☐ Rash
- ☐ Open sores on face
- ☐ Skin changes

At risk checklist:
- ☐ Overweight or obese
- ☐ High blood pressure
- ☐ Wears neck size >17 Men
- ☐ Wears neck size >16 Women
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ A Fib or other heart problems
- ☐ Congestive heart failure
- ☐ Stroke

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 chance 2=Moderate chance 3=High chance

Sitting and relaxing:_____

Watching television:_____

Movie theater/Meeting:_____

Passenger in car for over an hour:_____

Lying down to rest:_____

Sitting talking to someone:_____

Sitting after lunch:_____

While driving:_____

_____/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?_____

History Intake Form

Name_____ Date_____

Pharmacy_____

Referral_____ Primary Care Provider_____

PastMedical History:(Please check all that apply)

- ☐ NONE
- ☐ Anxiety
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Hypertension (High blood pressure)
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Hypercholesterolemia (High cholesterol)
- ☐ BPH (Benign prostate hypertrophy)
- ☐ Hyperthyroidism (High thyroid)
- ☐ Bone Marrow Transplantation
- ☐ Hypothyroidism (Low thyroid)
- ☐ Breast Cancer
- ☐ Leukemia
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ COPD
- ☐ Lymphoma
- ☐ Coronary Artery Disease
- ☐ ProstateCancer
- ☐ Depression
- ☐ Radiation Treatment
- ☐ Diabetes
- ☐ Seizure
- ☐ End Stage Renal Disease
- ☐ Stroke
- ☐ GERD (Gastro esophageal reflux disease)
- ☐ Other: _____

Past Surgical History :(Please circle those applied): NONE, Tonsillectomy, Hysterectomy, Gall Bladder, Appendix, Knee, Hip, Back, Shoulder

List other: _____

Medications: Please enter all medication (or proved copy)

Allergies:_____

Social History

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

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

Smoking: Yes/No **Alcohol:** No/Yes Rarely/social/occasionally/daily **Any illicit drug use:** Yes/No

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

Family History of Disease/Illness:

Mother: _____

Father_____

During the course of your current illness or in the past 2 weeks have you experienced any of the following symptoms? Please check all that apply.

☐ Fevers	☐ Sensation of spinning	☐ New loss of bladder control
☐ Chills	☐ Dizziness	☐ Loss of bowel control
☐ Cough	☐ Pain? Where?	☐ Pauses in breathing during sleep
☐ Headache	☐ Difficulty swallowing	☐ Snorting or choking arousals from sleep
☐ Stiff neck	☐ Weakness	☐ Falling asleep while driving or at work
☐ Skin changes	☐ Numbness	☐ Acting out dreams
☐ Rash	☐ Tingling	☐ Difficulty sleeping
☐ Nausea	☐ Incoordination	☐ Loud snoring
☐ Vomiting	☐ Trouble with walking	☐ Daytime tiredness
☐ Loss of consciousness	☐ Changes in handwriting	☐ Rapid or irregular heart beat
☐ Seizures	☐ Muscle cramps	☐ Pounding in chest
☐ Double Vision	☐ Loss of muscle size	☐ Diarrhea or loose stools
☐ Blurry vision	☐ Changes in weight	☐ Chest pain
☐ Loss of smell or taste	☐ Mood changes	☐ Shortness of breath
☐ Hearing loss (recent)	☐ Behavior changes	☐ Changes in sexual function/impotence
☐ Ringing in ears	☐ Confusion	☐
☐ Lightheadedness	☐ Trouble speaking	☐

<u>Epworth Sleepiness Scale:</u>

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

The Sleep Specialists

an Affiliate of Mountain View Hospital
PH:208-523-7667 Fax 523-7668

Idaho Falls - 2680 Channing Way, Idaho Falls, ID 83404
Rexburg - 155 West Main Street Suite 7, Rexburg, ID 83440
Blackfoot - 53 Poplar, Blackfoot, ID 83221

Name _____ Email _____
First Middle Last

Address _____
Street City State and Zip

Date of Birth _____ Age _____ Sex _____ Social Security# _____

Home Phone _____ Cell Phone _____ May we call you at work? _____

Occupation _____ Employer _____

Business Phone _____ Business Address _____

Spouses Name _____ SS# _____ Date of Birth _____

Person to notify in emergency _____
Name Phone #

Nearest friend or relative _____
Name Phone #

Referring Physician _____ Personal Physician _____

INSURANCE

Primary Insurance _____
Name of Insurance Policy # Group #

_____
Address Phone #

Policy Holder _____
Name SS # Date of Birth

Secondary Insurance _____
Name of Insurance Policy # Group #

_____
Address Phone #

Policy Holder _____
Name SS # Date of Birth

How did you hear about us? _____

Patient Name: _____ Date of Birth: ____/____/____

CONDITIONS OF ADMISSION TO THE SLEEP SPECIALISTS

an Affiliate of Mountain View Hospital

Idaho Falls - 2680 Channing Way, Idaho Falls, ID 83404
Rexburg - 155 West Main Street Suite 7, Rexburg, ID 83440
Blackfoot - 53 Poplar, Blackfoot, ID 83221

1. **CONSENT OF TREATMENT**: I, the undersigned, do consent to the services that may be performed during this clinic/outpatient visit under the general and special instructions of my provider. These may include, but are not limited to:

Procedures	Services
• **Lab** • **Radiology** • **Diagnostic** • **Stress Testing** • **Sleep Study**	• **Medical, nursing, and hospital** • **Anesthesia** • **Pathology** • **Emergency** • **Physical Intervention**

I will inform my provider of any medication or other substances that I am taking. If I take anything without my provider's knowledge and/or orders, I release the hospital, clinic, and physicians from any liability from the reactions that might occur. _____ **Initials**

2. **BLOOD TRANSFUSIONS:** In the event of an emergency, I authorize BLOOD or BLOOD PRODUCTS to be given to me. **YES**_____ **NO**_____

3. **RELEASE OF INFORMATION:** I understand my health care record—including provider notes, medical images, test results, etc.—is stored electronically on a secure hospital network and will be used for the purpose of treatment, payment and health care operations. In accordance with state and federal law, the hospital/clinic may provide access to my healthcare record to:

- All health care providers responsible for providing my health care during my treatment at this facility, during any ordered transportation to another facility, and at any receiving facility
- Any agencies responsible for payment, such as insurance companies
- My employer and/or its designee if my injury/illness is work-related
- Any governmental agency as required by law
- Local religious organizations who may be notified of my religious preference
- Medical researchers who will use this information anonymously and in aggregate

4. **PERSONAL VALUABLES:** The hospital/clinic shall not be liable for the loss and/or damage of any personal property.

5. **HOSPITAL/CLINIC VISITATION**: MVH will ensure that all visitors enjoy full and equal visitation privileges consistent with patient privileges. MVH welcomes all races, colors, national origins, religions, sexes, gender identities, sexual orientations, and abilities.

6. **WEAPONS/EXPLOSIVES/ILLEGAL DRUGS/ALCOHOL:** None of these are allowed in this facility. My person, belongings, and room may be searched if the staff suspects their presence. Any prohibited materials will be disposed as appropriate, including notification of law enforcement as necessary.

7. _____Yes	_____No	I received and understand "My Patient's Rights"
_____Yes	_____No	I received and understand the HIPAA Privacy Policy Act https://www.mountainviewhospital.org/privacy-notice
_____Yes	_____No	I have a durable power of attorney for healthcare
_____Yes	_____No	I wish to designate a Healthcare Information Coordinator
_____Yes	_____No	I possess a signed organ donor card
_____Yes	_____No	I wish to fill out an organ donor card
_____Yes	_____No	I understand that Mountain View Hospital, a physician-owned hospital, owns The Sleep Institute. A list of owners is available on request.

8. **MEDICARE PATIENT CERTIFICATION:** I certify that I have given complete and correct information if I applied for payment under Title XVII or Title XIX of the Social Security Act. I authorize any medical or other information holder to release any necessary information about any claim to the Social Security Administration, its intermediaries, or its carriers. 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.

I have read and understand the Conditions of Admissions and Authorization for Medical Treatment Form.
I have signed the Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.
No results have been promised, assured, or guaranteed.

☐ *Please check box if patient is medically unable to sign this Conditions of Admission*

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

_____ _____
Print Name — Date

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 be 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)

- □ Home Telephone _____
  - □ O.K to leave a message with detailed information
  - □ Leave message with call-back number only.
- □ Work Telephone
  - □O.K. to leave message with detailed information
  - □Leave message with call-back number only.
- □ Written Communication
  - □ O.K. to mail to my home address
  - □O.K. to mail to my work/office address
  - □O.K. to fax to this number _____
- □ Release to Spouse
  - □ O.K. to release Information
  - □Do not release information to spouse

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records or protected health information disclosures. Information provided below, if completely properly, will constitute and adequate record.

Note: Uses and disclosures of information may be permitted without prior consent in an emergency

Date	Disclosed to Whom	Purpose of Disclosure	By Whom

The Sleep Specialists

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2680 Channing Way, Idaho Falls, ID 83404
Phone (208) 523-7667 * Fax (208) 523-7668

ASSIGNMENT and RELEASE:

Office Policy: All charges are due at the time of service. Any additional charges are due and payable within 90 days. As a courtesy to our patients, we will file your insurance claim, however, you are responsible for all charges regardless of your insurance coverage. All collection agency fees and attorney fees will be incurred by the patient if not paid as agreed. In addition, if your account is turned over to a collection agency for failure to pay, you will incur an additional fee equal to 100% of the balance due and you will be discharged from this practice.

You may be discharged from the practice if you no show for two appointments. Additionally, if you do not show up for an appointment or cancel an appointment with less than 24 hour notice, you will be charged a $50.00 no show fee, which will not be covered by insurance.

I hereby authorize Dr. Talcott to release any information acquired in the course of my examination or treatment to my insurance company. I also authorize payment directly to Mountain View Hospital for medical services.

_____
PRINT NAME

_____ _____
SIGNATURE DATE

Patient Name: _____ Date of Birth:____/_____/_____ Current Date: _____

CLINIC CONDITIONS OF ADMISSION TO THE SLEEP SPECIALISTS

an Affiliate of Mountain View Hospital

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, diagnostic procedures, stress testing, rendered to me under the general and special instructions of my physician. 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 physician orders such tests for diagnostic purposes. If the patient takes any medications or other substances without orders from the physician, the patient hereby releases the hospital and physician from liability for any reaction that may occur. In the event of an emergency, **I authorize MVH to transfer myself to another health care facility should my physician 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 physician 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, 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, physicians involved in my care and their offices.
3. PATIENT PRIVACY: I have read and/or received the information sheet entitled:
   "HIPPA 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. 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.
5. 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 specific instructions of my physician 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 a reasonable attorney's fees, 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 costs of suit.
6. 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 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.
7. MOUNTAIN VIEW HOSPITAL IS A PHYSICIAN OWNED HOSPITAL: Upon request a List of Ownership will be provided to you.

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 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.

❑ *Please check box if patient is medically unable to sign this Conditions of Admission*

_____ _____

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

_____ _____ _____

Print Name Date Witness: