Stephanie Zandieh, M.D., M.S., FCCP, FAAP, Diplomate ABSM
Director, Pediatric Sleep Medicine

Kim Cahill, R.N., MSN, APN, CPNP-PC

Valley Medical Group
Valley Health System
Pediatric Sleep Medicine

Dear Parent,

Thank you for contacting the Pediatric Sleep Disorders and Apnea Center to schedule your child's consultation appointment. Consultation appointments may last 1 hour.
Late arrivals will necessitate rescheduling. **Please assist us by completing and returning enclosed forms. If you find it necessary to cancel or change your appointment, please notify us as soon as possible at 201-447-8152. Patients will be charged a "no show" fee of $25.00 for appointments not cancelled within 24 hours.**

The following information is provided to assist you in working with your healthcare insurance company. The information is intended as a guideline and is based upon previous patient encounters. You may refer to the codes below when verifying your benefits and eligibility. If your plan requires a referral, please have it prepared with the following information:

Services to be referred:

- 99244–99245 Initial Consultation, new patient office visit/evaluation
- 95810 Polysomnography (sleep testing)
- 99213–99215 Office Consultation, follow–up visit to discuss results and plan of care

If your healthcare company requires precertification or prior authorization for outpatient procedures, we will provide them with the requested clinical information along with the diagnosis and procedure codes. Please keep in mind that precertification or prior authorization is not a guarantee of payment.

Thank you for giving us the privilege of participating in the care of your child.

Sincerely,

Stephanie Zandieh, MD

Stephanie Zandieh, M.D., M.S.
Director, Pediatric Sleep Medicine

QUICK PATIENT REGISTRATION FORM

Patient Information:

Legal First Name: _____MI: ___ **Legal Last Name**:_____

Sex: M F **Date of Birth:_____** **Marital Status:** Married Single Partner Divorced Widowed

Primary Language:_____ Race: _____ Ethnicity: _____

_____ _____ _____ _____
Address City State Zip Code

_____ _____ _____ _____
Home phone Cell phone Work phone Email

Preferred method of contact (circle one): Home Phone Cell Phone Work Phone Email

Would you like access to the patient Portal? Y N **May we text you to confirm an appointment?** Y N

Patient Insurance:

Insurance Information: Are you the Primary Cardholder: Y N

If No: Name of Cardholder:_____ Relationship_____ Date of Birth _____

Do you have a Secondary Insurance: Y N

Name of Cardholder:_____ Relationship_____ Date of Birth _____

Is this a Workers Compensation visit? Y N Your social security # _____ Date of Injury:_____
(If no, skip to Emergency Contact section)

Description of Injury_____

Employer Name:_____ Phone:_____ Fax:_____

Address:_____

Supervisor Name:_____

Has treatment for today's injury been authorized? Y N If Yes, by whom? _____

Workers Comp Insurance Carrier Name:_____ Contact:_____

W/C Carrier Address:_____

W/C Carrier Phone:_____ W/C Carrier Fax:_____ W/C Claim #_____

Your Position/Job Title: _____

Emergency Contact:

Contact Name: _____ Contact Phone _____

Relationship to Patient:: _____ Contact Cell Phone: _____

Referring Provider:

Name: _____ Phone: _____

Address:_____

Pharmacy:

Name: _____ Phone: _____

Address:_____

Mail Order Pharmacy Name: _____ Policy Number: _____

Phone: _____ Fax: _____

Primary Care Provider:	**Lab Preference:**
Name: _____	Name: _____
Phone: _____	Phone: _____
Address: _____	Address: _____

Patient Signature:_____Date/Time: _____

GENERAL CONSENT FOR TREATMENT

1. I, _____, hereby consent to treatment by the Valley Medical Group (VMG)* and its physicians, staff and/or agents. I understand that my treatment may include testing (for example, x-rays and blood tests), routine care and procedures (for example injections), and evaluation (for example, interviews and physical exams). This general consent does not include consent for invasive procedures (for example, surgery), which require a separate consent process. I understand that the practice of medicine is not an exact science and no guarantees have been made to me about the outcome of my care and treatment. I acknowledge VMG's authority to dispose of specimens taken for laboratory or pathology examination according to its usual procedures.

2. I understand and agree that VMG may have access to my medical and billing information. I understand that under the law this information may be used and disclosed for treatment, payment and healthcare operations. I understand and agree that the information disclosed about me may include information about and/or reference HIV/AIDS related diagnoses/conditions, drug or alcohol use or abuse, pain management and psychiatric or psychological information, reports, evaluations and diagnoses, as well as history and physical examinations results, consultations and treatment recommendations. VMG is authorized to disclose all or part of my information as set forth above, unless I object in writing.

3. I understand that in order to facilitate my care and treatment, VMG may need to access information about me, including my prescription history and information from my other providers and facilities where I have received care and services, such as specialists, diagnostic centers, and laboratories.

4. After treatment is received, I agree to follow the medical advice and instructions given by VMG and to continue treatment and follow-up care as recommended by VMG.

5. I understand and agree that I am financially responsible to pay for any services I receive in accordance with the regular rates and terms of VMG. I agree to make prompt payment to VMG for any and all charges not paid for by my health insurer or payor, to the fullest extent permitted by law.

6. I understand that my health insurer or payor may require that I obtain pre-certification and/or pre-authorization for the services provided to me, and that I am responsible for any charges for health care services that are not pre-certified and/or pre-authorized. I acknowledge that it is my responsibility to understand my insurance coverage requirements, benefits and limitations.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS GENERAL CONSENT FOR TREATMENT, AND THAT ANY QUESTIONS THAT I HAD ABOUT IT HAVE BEEN ANSWERED TO MY SATISFACTION BY THE STAFF OF THIS FACILITY.

_____ _____

Patient or Authorized Representative Signature | Date and Time

_____ _____

Name of Person Signing | Relationship to Patient

The patient is unable to consent because:

_____

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC. and Valley Medical Services, PC. and Valley Physician Services, NY, PC

NOTICE OF PRIVACY PRACTICES

Effective as of: September 13, 2013
Revised: November 27, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact the Chief Operating Officer, Valley Medical Group by calling 201-291-6456.

WHO WILL FOLLOW THIS NOTICE

This Notice describes Valley Medical Group's practices and that of:

- Any healthcare professional authorized to enter information into your patient chart.
- All departments and units of Valley Health System (System), including The Valley Hospital; Valley Home Care, Valley Medical Group; and The Valley Hospital Foundation.
- Any member of a volunteer group we allow to help you while you are at a Valley Medical Group facility.
- All employees, staff, and other Valley Health System personnel.
- The Valley Hospital; Valley Home Care; Valley Medical Services t/a Valley Medical Group; Valley Physician Services t/a Valley Medical Group; Valley Physician Services NY, PC t/a Valley Medical Group; Valley Medical Group; and The Valley Hospital Foundation follow the terms of this Notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment or operations purposes described in this Notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by any Valley Medical Group facility.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of our legal duties and privacy practices concerning medical information about you; and
- follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

We use and disclose medical information in many ways. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, nursing and medical students, or other personnel who are involved in taking care of you and who may call to see how you are doing. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments within the System also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work, and X-rays. We also may disclose medical information about you to people outside Valley Medical Group who may be involved in your medical care, such as family members, clergy, rehabilitation centers or others we use to provide services that are part of your care.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about the care you received so your health plan will pay us or reimburse you for services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations**. We may use and disclose medical information about you for the facility's operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services should be offered, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, nursing and medical students, and other System personnel for review and learning purposes. We may also combine the medical information we have with medical information from other medical groups to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

- **Health Information Exchange**. Consistent with federal regulation, we have partnered with Jersey Health Connect, which is a Health Information Exchange (HIE). An HIE is governed by a strict set of rules designed to protect patient confidentiality, privacy and security. The purpose of an HIE is to allow physicians and healthcare facilities to share your clinical information electronically. The goals of this exchange are to reduce medical errors, eliminate redundant care and reduce unnecessary costs. Ultimately the HIE will also allow you to access your information stored in the HIE and become a more active, informed participant in your overall care. You are entitled to opt-out of this HIE by contacting Jersey Health Connect at 855-624-6542 or via the internet at http://www.jerseyhealthconnect.org/.

- **Appointment Reminders**. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at a Valley Medical Group facility.

- **Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services**. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

  Fundraising Activities. We may use demographic information about you, such as name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of services, department of services, treating physician or information regarding outcome, to contact you in an effort to raise money for the hospital, home care or hospice. We may disclose medical information to The Valley Hospital Foundation so that the Foundation may contact you in raising money for the hospital, home care or hospice. You are free to opt-out of fundraising solicitation and your decision will have no impact on your treatment or payment for services. If you do not want the hospital to contact you for fundraising efforts, you must notify us. If you do not want the Foundation to contact you for fundraising and you wish to opt-out of these contacts, you may call the Foundation at 201- 291-6300. You may also opt-out of these contacts by contacting the Foundation in writing at The Valley Hospital Foundation, 223 North Van Dien Avenue, Ridgewood, New Jersey 07450-2736.

- **Individuals Involved in Your Care or Payment for Your Care**. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition.. In addition, we may disclose medical information about you to an entity helping in a disaster relief effort so that your family can be notified about your condition, status, and location.

- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the facility.

- **As Required By Law**. We will use and disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Business Associates**. We may disclose medical information about you to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract or as permitted by federal, state or local law.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans**. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks**. We may disclose medical information about you for public health activities. These activities generally include the following:

  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC. and Valley Physician Services, NY, PC

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

➢ **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

➢ **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official:

in response to a court order, subpoena, warrant, summons or similar process;

to identify or locate a suspect, fugitive, material witness, or missing person;

about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

about a death we believe may be the result of criminal conduct;

about criminal conduct at hospital medical group facility; and

in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **Coroners, Medical Examiners, and Funeral Directors**. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

➢ **National Security and Intelligence Activities**. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

➢ **Protective Services for the President and Others**. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

➢ **Correctional Institutions**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

➢ **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may
be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by the medical group will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

➢ **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all the information, both old and new, is kept by or for the medical group.

To request an amendment, your request must be made in writing and submitted to the. Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652 In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

is not part of the medical information kept by or for the medical group;

is not part of the information which you would be permitted to inspect and copy; or
is accurate and complete.

➢ **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment, and healthcare operations.
To request this list or accounting of disclosures, you must submit your request in writing to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

➢ **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure you had.

We are not required to agree to your request in most cases. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or as required by law. We are required by law and will agree to restrict disclosure of your medical information if your request pertains solely to a disclosure to a health plan when you have paid for services out-of-pocket and in full. For example, if you pay for a service completely out of pocket and ask us not to tell your insurance company about it, we will abide by this request.

To request restrictions, you must make your request in writing to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➢ **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to follow your request.

➢ **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our web site, www.ValleyHealth.com.

To obtain a paper copy of this Notice, please write to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652.

➢ **Right to be Notified of a Breach.** You have the right and we will notify you of any breach of your unsecured protected health information.

CHANGES TO THIS NOTICE.
We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice in the facility. The Notice will contain on the first page, in the top left-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current Notice in effect.

COMPLAINTS.
If you believe your privacy rights have been violated, you may file a complaint with the medical group or with the Secretary of the Department of Health and Human Services at the Office of Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278. To file a complaint with the medical group, please write to the Chief Operating Officer, Valley Medical Group, 15 Essex Road, Paramus, NJ 07652. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. Such information includes most (i) uses and disclosures of psychotherapy notes (if recorded by us); (ii) uses and disclosures of your protected health information for marketing purposes; (iii) disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures that may not be described in this Notice.

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

For further information, please contact the Chief Operating Officer Valley Medical Group, 15 Essex Road, Paramus, NJ 07652, 201-291-6456.

Valley Medical Group
Valley Health System

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge by signing below that I have received or have been given the opportunity to receive a copy of Valley Medical Group Notice of Privacy Practices.

HIPAA

_____ _____

Patient Name (please print clearly) Date

_____

Patient/Guardian Signature

_____ _____

Person Signing on behalf of the patient Relationship to Patient

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY, PC

AUTHORIZATION TO DISCUSS HEALTH INFORMATION WITH OTHERS AND/OR LEAVE TELEPHONE MESSAGES

The purpose of this document is to inform us if we have your permission to:

- Relay information to other people regarding your care and treatment.
- Leave information about your care and treatment on your telephone answering machine.
- Call you at work, and/or on your cell phone or other telephone number.

Patient Name:_____ **Date of Birth**:_____

When our physicians or office staff need to speak with you about your healthcare, we generally place a telephone call and ask to speak with you, our patient, first. Some examples of when we may need to call you are: to schedule/change/cancel an appointment; to see how you are feeling after a visit to us; with follow-up instructions after a visit; and/or to provide laboratory, radiology, or other diagnostic test results, etc.

- PREFERRED METHOD FOR OUR FOLLOW-UP COMMUNICATIONS WITH YOU:

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Work Phone _____

If you are unavailable when we telephone you,

- May we leave a detailed message about your care and treatment on your answering machine? ☐ Yes ☐ No

- Is there another person that we have permission to speak with regarding your health care? If "Yes", please specify who:

Name	Relationship	Phone #	Type of Information
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions
			☐ Appointments ☐ Test Results ☐ Billing ☐ Medical Care Instructions

_____ _____

Patient or Authorized Representative Signature Date

_____ _____

Name of Person Signing Relationship to Patient

Valley Medical Group will abide by the guidelines given in this document unless you instruct us differently.

PATIENT RESPONSIBILITIES AND STATEMENT OF UNDERSTANDING

In the current healthcare environment, it is increasingly difficult for medical providers to be paid for their services. Dealing with insurance companies is also becoming more confusing to our patients. As a result, we would like to clarify your responsibilities as a Valley Medical Group patient.

Insurance Coverage

- Your insurance policy is a contract between you and your insurance company, not your provider.
- Changes to your insurance coverage must be communicated to our office at the time of service upon check-in.
- Your insurance company may require you to choose a primary care physician in order to receive "in network benefits". If you have chosen a Valley Medical Group physician as your PCP and his or her name does not appear on your insurance card, you must verify that your insurance company has the correct information before services are rendered.
- If your claim is processed incorrectly by your insurer, you give Valley Medical Group permission to appeal the claim on your behalf by your signature below.
- If your insurance plan requires a PCP and the Valley Medical Group physician is not your PCP, you may be responsible for deductibles, co-insurance, and other non-covered services.
- If your plan requires referrals from your Valley Medical Group PCP to specialists, it is your responsibility to obtain the referral from our office prior to your appointment with the specialists. Please be aware that non-emergent referrals can take up to two weeks to process. In addition, referrals will **NOT** be dated retroactively.

Financial Obligations

1. Co-payments are due at the time of service.
2. Valley Medical Group will bill participating insurance companies after verifying coverage. If claims are not paid, Valley Medical Group will bill you for services rendered.
3. Payment for non-covered services, deductibles, and co-insurance amounts are due within thirty (30) days of receipt of invoice.
4. If insurance payments are paid to you in error instead of Valley Medical Group, the payment must be forwarded to us. You may issue a personal check to Valley Medical Group. Be sure to include a copy of your insurance company's documentation or explanation of benefits.
5. If you do not have insurance that Valley Medical Group participates with, you are responsible for payment in full for today's services.
6. Processing fees may be imposed for non-payment of out-of-pocket expenses referenced in #1 and #5 above, and for checks returned by the bank for non-payment.
7. Valley Medical Group bills an additional fee for weekend and holiday visits.
8. If requested, you are responsible for providing your insurance company with any other insurance coverage, details of an injury, dependent student information, and other non-medical information. Failure to comply with an insurance company request for information will result in your being responsible for payment.

I HAVE READ AND UNDERSTAND THE INFORMATION AND MY RESPONSIBLITIES AS STATED ABOVE:

Patient/Guardian:_____ Date: _____

Witness:_____ Date: _____

A copy of this form is available upon request.

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY, PC

Valley Medical Group
Valley Health System

Date: _____

E-Prescribing/Medication History Consent Form

Patient Name: _____ Date of Birth: _____

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- Formulary and benefit transactions – gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification – allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Valley Medical Group* can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Valley Medical Group to enroll me in the e-Prescribe Program. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Witness to Signature(s) Patient's or Authorized Representative's Signature

_____

Relationship to Patient

*Valley Medical Group is the "trading as" name for Valley Physician Services, PC, Valley Medical Services, PC and Valley Physician Services, NY, PC

Stephanie Zandieh, M.D.
Kim Cahill, APN
Pediatric Sleep Medicine
579 Franklin Turnpike, 2nd Floor
Ridgewood, NJ 07450
201-447-8584

Valley Medical Group
Valley Health System
Pediatric Sleep Medicine

Sleep/Medical Questionnaire

Name: _____ Date: _____

Referring Physician_____

Date of Birth _____ Marital Status _____ Number of Children _____

Please try to answer all questions. If possible, obtain the assistance of your bed-partner.

1. Briefly describe your main sleep problem, including when and how this began:

_____

_____

_____

2. Extent of problem:

How long have you had this problem? ☐ Months _____ ☐ Years ____

How often does this problem occur? ☐ Almost every night ☐ Other _____

How severe is the problem? ☐ Mild ☐ Moderate ☐ Severe

3. Prior evaluation & treatment - have you previously had evaluation of your sleep problem with:

☐ Physician ☐ Sleep specialist ☐ Psychiatrist/Psychologist ☐ Other _____

Have you had a sleep study? _____ When: _____

Have you been diagnosed with sleep apnea or any other sleep disorder? _____
What type? _____ Current treatment_____
Prior treatment _____

4. Please indicate if you are experiencing any of the following sleep problems:

☐ Difficulty falling asleep
☐ Wake up frequently during the night
☐ Prolonged awakening during the night
☐ Snoring
☐ Stop breathing during sleep
☐ Restless legs
☐ Wake up early in the morning
☐ Difficulty awakening
☐ Get too little sleep at night
☐ Difficulty staying awake during the day

5. Do you do any of the following shortly before bedtime?

☐ Drink coffee or tea ☐ Drink alcohol ☐ Physical exercise
☐ Watch TV in bed ☐ Read in bed ☐ Read out of bed
☐ Work in bed ☐ Work out of bed ☐ Work on computer

6. Do you take any of the following medications or drugs?

☐ Sleeping pills
☐ Pills to stay awake/ stimulants
☐ Sedatives/ tranquilizers

7. Sleep pattern:

How long does it usually take for you to fall asleep? _____ minutes _____ hours
Usual bedtimes? Weekdays: bedtime: _____ wake time: _____
Weekends: bedtime: _____ wake time: _____

Do you work rotating shifts or night shifts? _____ Describe:_____

How much does your bedtime and wake time vary? _____

Do you frequently travel across time zones? _____

8. How many hours of sleep do you usually get during the night? _____

9. How many times do you typically wake up during the night? _____

10. If you awaken during the night, when does this occur?
☐ Soon after falling asleep ☐ In the middle of the night ☐ Early morning

How long do you stay awake, on average? _____

What do you usually do when you awaken during the night?
☐ Stay in bed ☐ Read in bed ☐ Read out of bed ☐ Exercise ☐ Eat
☐ Watch TV ☐ Computer ☐ Chores ☐ Other _____

Do you have a fear of not being able to get back to sleep? ☐ Yes ☐ No

11. Indicate the reason(s) that you wake up during the night:
☐ Snoring ☐ Gasping/choking ☐ Heartburn/reflux ☐ Need to urinate
☐ No obvious reason ☐ Leg kicking/jerking ☐ Dry mouth ☐ Leg cramps
☐ Hunger/thirst ☐ Heat/cold ☐ Noise ☐ Light
☐ Awakened by bed partner ☐ Other _____

12. Do you usually (check all that apply):
☐ Sleep with someone else in your bed
☐ Sleep with pet in your bed
☐ Provide assistance during the night (e.g. to child, invalid)

13. How do you feel after an average night of sleep?
☐ Good most of the time ☐ Groggy/sleepy ☐ Poorly refreshed
☐ Have headache ☐ Have jaw pain ☐ Have dry mouth/throat

14. Do you experience sleepiness during the daytime?
☐ None ☐ Mild ☐ Moderate ☐ Severe

When do you feel most sleepy? ☐ Morning ☐ Afternoon ☐ Evening
Do you take naps during the day? ☐ No ☐ Yes
Do you feel refreshed after a nap? ☐ No ☐ Yes

15. Please rate how often you do the following:
0 = never 1 = rarely 2 = sometimes 3 = frequently 4 = usually or constantly

_____ Snore
_____ Snore loudly enough that others complain
_____ Stop breathing at night (observed by yourself or others)
_____ Awaken from sleep gasping for breath or choking
_____ Awaken from sleep with heartburn or belching
_____ Awaken with chest pain
_____ Awaken from sleep with cough
_____ Wake during the night for no apparent reason
_____ Sweat excessively at night
_____ Notice your heart pounding or beating irregularly during the night

_____ Fall asleep during the daytime
_____ Fall asleep involuntarily e.g. while driving
_____ Have trouble at work or school because of sleepiness
_____ Feel paralyzed/ unable to move when waking or falling asleep
_____ Experience loss of muscle tone when laughing, angry or emotional
_____ Experience vivid dream-like scenes or hallucinations upon awakening or falling asleep
_____ Have very vivid dreams or nightmares
_____ Kick, jerk or twitch repetitively during the night
_____ Experience restless legs, urge to move your legs
_____ Experience crawling, tingling or aching feeling in your legs
_____ Experience electric-like or other leg pain during the night
_____ Experience painful leg cramps during the night
_____ Walk in your sleep
_____ Eat in your sleep
_____ Talk in your sleep
_____ Act out dreams
_____ Fall out of bed
_____ Have convulsions or seizures during sleep
_____ Wet your bed
_____ Have thoughts racing through your mind
_____ Have anxiety (or worry about things) at bedtime
_____ Experience panic
_____ Fear of not falling asleep or getting enough sleep
_____ Experience poor night sleep
_____ Grind teeth during the night
_____ Bothered by/ awakened by pain during the night
_____ Wake up feeling stiff in the mornings
_____ Experience fatigue (exhaustion) even when not sleepy

16. Does your sleep problem disturb your sex life or social life? ☐ Yes ☐ No
Describe_____

17. Personal Habits: Do you regularly drink any of the following?

_____ Alcohol Daily quantity _____
_____ Caffeinated Coffee Daily quantity _____
_____ Caffeinated Tea Daily quantity _____
_____ Caffeinate soft drinks Daily quantity _____
_____ Chocolate Daily quantity _____

18. Please indicate if you experience any of the following:

☐ Headaches	☐ Need antacids regularly	☐ Fatigue
☐ Feel panicky	☐ Nightmares	☐ Stomach troubles
☐ Feel Tense or Anxious	☐ Memory problems	☐ Difficulty concentrating
☐ Feel Depressed	☐ Suicidal ideas	☐ Feel full of anger
☐ Unable to relax	☐ Sexual problems	☐ Palpitations
☐ Alcoholism	☐ Difficult home conditions	☐ Fainting spells
☐ Unable to have a good time	☐ Inferiority feelings	☐ Other_____

19. Do any other members of your family have sleep apnea or other sleep problems? Please describe.
_____

20. With whom are you now living? _____

21. Please describe any other information pertinent to your sleep or wakefulness not previously provided.
_____

22. History of Cigarette Smoking:

___ Never smoked
___ CURRENTLY smoke _____#packs/day _____# years smoking
___ FORMER smoker _____#packs/day _____# years smoked _____# years stopped

23. Allergies: Are you allergic to any of the following? Please specify:

☐ Medications (antibiotics, others): _____
☐ Environmental (e.g., pollen, mold, dust, animals): _____
☐ X-ray dye/Iodine_____
☐ Shellfish/seafood_____
☐ Latex
☐ Eggs
☐ Pets
☐ Other _____

24. Other Medical Problems: Have you EVER had any of the following medical problems?
List date, number of years:

☐ High blood pressure _____
☐ Heart disease _____
☐ Rheumatic fever_____
☐ Ulcers _____
☐ Stroke _____
☐ Bleeding problems_____
☐ Blood Clot_____
☐ Cancer: _____Type:_____
☐ Severe Allergic Reaction _____
☐ Diabetes_____
☐ Heart Attack _____
☐ Abnormal heart rhythm _____
☐ Liver problems _____
☐ Anemia _____
☐ Kidney problems_____
☐ Thyroid problems_____
☐ Gastric reflux _____
☐ Rheumatoid arthritis _____

25. Other Symptoms: Have you EVER had any of the following symptoms or problems?

☐ Poor appetite	☐ Weight gain _____lbs.	☐ Excessive appetite
☐ Excessive sleepiness	☐ Weight loss _____lbs.	☐ Chest pain
☐ Swelling of legs/ankles	☐ Excessive snoring	☐ Recent fever
☐ Night sweats/chills	☐ Joint pain	☐ Muscle/bone pains

26. Medications:

Do you routinely take any of the following medications?

Ambien (zolpidem)	☐ Yes	☐ No	Lunesta (eszopiclone)	☐ Yes	☐ No	Halcion	☐ Yes	☐ No
Rozerem	☐ Yes	☐ No	Sonata (zaleplon)	☐ Yes	☐ No	Restoril	☐ Yes	☐ No
Inermezzo	☐ Yes	☐ No	Silenor (doxepin)	☐ Yes	☐ No	Xanax	☐ Yes	☐ No
Narcotic for Pain	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Steroid	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Antidepressant	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Antihistamines	☐ Yes	☐ No	Anti-anxiety/tranquilizer	☐ Yes	☐ No	Stimulant/ADHD	☐ Yes	☐ No

27. Hospitalizations/Surgeries: Please list all prior hospitalizations and surgeries.

Year	Reason	Year	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

28. Family History: Check all family members who have/ had the following diseases:

	Mother	**Father**	**Sister**	**Brother**	**Grand mother Maternal**	**Grand mother Paternal**	**Grand father Maternal**	**Grand Father Paternal**	**Other**
Deceased?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Asthma									
Emphysema									
Chronic bronchitis									
Bronchiectasis									
Interstitial fibrosis									
Sleep apnea									
Narcolepsy									
Insomnia									
Restless legs									
Cancer									
Diabetes									
Heart disease									
High blood pressure									
Stroke									
Other									

29. <u>Insomnia Severity Index</u>

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

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	☐	☐	☐	☐	☐
Difficulty staying asleep	☐	☐	☐	☐	☐
Problem waking up too early	☐	☐	☐	☐	☐

How SATISFIED or DISSATISFIED are you with your current sleep pattern?
☐ Very Satisfied ☐ Satisfied ☐ Moderately Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

How NOTICIBLE to others do you think your sleep problem is in terms of impairing the quality of your life?
☐ Not at all Noticeable ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Noticeable

How WORRIED/DISTRESSED are you about your current sleep problem?
☐ Not at all Worried ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Worried

To what extent do you consider your sleep problem to INTERFERE with your CURRENT functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?
☐ Not at all Interfering ☐ A Little ☐ Somewhat ☐ Much ☐ Very Much Interfering

30. Patient Health Questionnaire: Over the last 2 weeks, how often have you been bothered by the following problems?

0 = Not at All | 1 = Several Days | 2 = More than Half the Days | 3 = Nearly Every day

	0	1	2	3
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or have let yourself or family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or in the opposite being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

31. Generalized Anxiety Disorders: Over the last 2 weeks, how often have you been bothered by the following problems?

0 = Not at All 1 = Several Days 2 = More than Half the Days 3 = Nearly Every day

	0	1	2	3
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being too restless so that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

32. Epworth Sleepiness Scale

In the situations listed below, how likely are you to doze off or fall asleep, in contrast to just feeling tired: (This refers to your usual behavior currently.) If you have not done some of these things recently, try to determine how they might affect you.

Use the following scale to choose **the most applicable** number for each situation and enter it on the line to the right of the situation described:

0 = Would NEVER doze off
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 SCORE: _____

33. Restless Leg Syndrome (RLS) Rating Scale

Restless leg syndrome is a condition in which there is an uncomfortable, tingly or painful sensation in the legs (or arms), or a strong need to move the legs (or arms).

0 = None
1 = Mild
2 = Moderate
3 = Severe
4= Very Severe

1. Overall, how would you rate the RLS discomfort in your legs or arms? _____
2. Overall, how would you rate the need to move around because of your RLS symptoms? _____
3. Overall, how much relief of your RLS arm or leg discomfort do you get from moving around? _____
4. Overall, how severe is your sleep disturbance from your RLS symptoms? _____
5. How severe is your tiredness or sleepiness from your RLS symptoms _____
6. Overall, how severe is your RLS as a whole? _____
7. How often do you get RLS symptoms? _____
8. When you have RLS symptoms, how severe are they on an average day? _____
9. Overall, how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs, for example carrying out a satisfactory family, home, social, school, or work life? _____
10. How severe is your mood disturbance from your RLS symptoms: (angry, sad, anxious, or irritable)? _____

TOTAL SCORE: _____