COLLIN COUNTY SLEEP DIAGNOSTICS
7000 PARKWOOD BLD, SUITE A-300
Frisco, TX 75034
TEL (972) 346-1811 FAX (972) 3546-1812
WEBSITE www.collincountysleep.com **EMAIL**: info@collincountysleep.com

Dear Sleep Patient,

You are scheduled to have a Sleep Study at Collin County Sleep Diagnostics on _____at _____P.M.

About Polysomnography:

What to expect: It takes approximately 45 minutes to 1 hour to get you "hooked-up" for the POLY (many) SOMNO (sleep) GRAM (recording). We will be placing wires, belts and flow measuring devices on you that will monitor your brain waves, eye movement, chin movement, breathing flow, oxygen, EKG, breathing effort, snoring, leg movement, and body position. This sounds like a lot of equipment, but most patients sleep well, as the lab is quiet.

All sleep studies are fully monitored. There is a central control room, in which the sleep technician monitors you from. A camera and a one way intercom are open to your room at all times, so if you need to get up and go to the bathroom, wave to the camera and the sleep technician will come in and disconnect you from the computer. All the monitoring devices are connected into what is called a "headbox" and this can be disconnected and carried with you. Don't be shy if you need extra covers, water or if anything is bothering you please let the tech know. We like "Lights out" at 11:30pm but if you fall asleep earlier that is fine, if you fall asleep with the television or light on, don't worry the technician will come in and turn them off for you. We would like you to sleep at least five hours or more. "Lights on" usually occurs at 5:00am.

If your doctor ordered what is called a "split study." This means that if you stop breathing (Obstructed sleep apnea) a certain amount of times during the sleep study or your oxygen levels drop, we will use a device called a CPAP (Continuous Positive Airway Pressure) to establish the appropriate pressure to hold your air passages open. This will regulate your breathing; eliminate obstructions (apnea) and snoring if you snore. We will show you a video before you go to bed that will explain this device and the reason for its use in more detail.

Patient Instructions:

1. Please eat dinner 2-3 hours before arriving for your test.
2. Bring comfortable sleep -wear with you, as well as a favorite pillow (if any), and reading material if needed. We also have a television in your room in case you watch TV before falling asleep.
3. Bring a list of any medications you are currently taking. Also, prior to arriving, bring any medications that you usually take prior to falling asleep or medication to make you sleepy.
4. **DO NOT** drink any alcoholic beverages prior to your test and on the day of your study please try to limit yourself to 2 cups of caffeine before noon

5. Try not to Nap during the day of your study.
6. Please have you hair free of excess oils and chemicals, due to the placement of electrodes on certain areas of your head. No wigs or extensions during the placement of electrodes as they can get ruined.

Attached to this package please find:

1. Our office Privacy Policy (for you to keep).
2. Please fill out the Questionnaire and bring it with you the night of your study.
3. Frequently asked questions about Sleep studies
4. Map to our facility with directions.
   NOTE: Please park in front of the facility.

We are open Monday through Friday 9am – 5pm for regular business hours; you may also stop by our facility for a tour prior to your sleep study. **If for any reason you need to cancel or re-schedule your appointment please do so 48 hours prior to your sleep study, otherwise there is a $200.00 late cancellation fee (this fee is not covered by your insurance).** Please leave any valuables at home when scheduled for your sleep study.

We hope this information is helpful and answers most of your questions. Should you have any questions please contact our office at (972) 346-1811.
See you on your sleep study and thank you for allowing us to serve you.

Sincerely,

Collin County Sleep Diagnostics

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Tel: (972) 346-1811 Fax: (972) 346-1812

PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY

Reason for a privacy policy
It is our desire to communicate to you that we are taking the new federal (HIPPA) Health insurance Portability and Accountability Act Laws written to protect the confidentiality of your health information seriously. The changes in the evolution of computer technology that is used in healthcare have prompted the government to seek a way to standardize and protect the electronic exchange of your health information. Collin County Sleep Diagnostics respects your privacy; we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your test results, diagnosis and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state laws allow us to use and disclose your protected health information for purposes of treatments and health care operations. State law requires us to get your authorization to disclose this information for payment purpose.

Uses and Disclosures of Your Medical Information:

- Treatment- Information obtained by the Collin County Sleep Diagnostics or members of our health care team will be recorded in your medical records and will be used to help decide what care may be right for you. We may also provide information to others providing your care. This will help stay informed about your care.
- Payment- Billing information to your insurance company, disclosures to consumer reporting agencies, (limited to specified identifying information about an individual, his/ her payment history, and identifying about the covered entity.)
- Health Care Operations- such as quality assurance reviews, coordination of care, and eligibility verification.
- Public Health Activities- such as child abuse or neglect.

In addition to the above, your medical information may be used or disclosed for emergency treatment, when we are required by law to treat you, we attempt to obtain consent, and are to do so; we are unable to obtain consent due to substantial communication barriers and consent for treatment is implied under circumstances; or we created or received the information in treating an inmate.

You have a right to:

- Request restrictions on certain uses and disclosures; however, we are not required to agree to any restriction.
- Receive confidential communications from us, upon written request.
- Inspect and request copies of your medical information.
- Receive an accounting of any disclosures made, upon written request.
- Receive a paper copy of the notice upon request or review out entire policy.

We are responsible for:

- Maintaining the privacy of your medical information.
- Providing you this notice and obtaining written acknowledgement.
- Abiding by terms of this notice.
- Providing written notice of any changes to this notice.

Complaints:
You may complain to us if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager, Carolina Pereira at her confidential email info@collincountysleep.com, voicemail ((972) 346-1811, fax (972) 346-1812 with written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond to all notices within two (2) weeks of receipt, and we will not retaliate for any allegations you make.

Authorizations:
Upon your authorization, we may disclose your medical information to a requesting entity, such as an attorney, another insurance company (apply for life insurance), or a relative. You may revoke any authorization you make at any time except to the extent that it is already relied on.

COLLIN COUNTY SLEEP DIAGNSOTICS

Most Frequently Asked Questions about Sleep Studies

1) Why do I need a sleep study?
Your doctor believes you show signs of sleep apnea, or he/she wants to rule out sleep apnea. Indications of sleep apnea are: excessive daytime sleepiness, snoring, gasping for breathe during sleep and difficulty falling asleep. These are just a few symptoms associated with sleep apnea.

2) What is a Sleep Study?
A sleep study is a diagnostic test using elements and wires that provide several types of measurements used to identify different sleep stages and classify various sleep disorders. This procedure is not painful or uncomfortable and is very safe. Small sensors are connected to the head, face, chest and legs of the patient to monitor different brain and body activities including brain waves, eye movement, heart rate, respiration and muscle movements.

3) Can I Fall Asleep With All Those Wires On Me?
Every effort is made to make the study as comfortable as possible so that it feels like another night to you. The sensor wires are gathered together to make it easy for the patient to roll over and change position. After a few minutes in bed, you will not even feel the presence of the sensors, and they can be easily be disconnected if you need to go to the bathroom in the middle of the night.

4) What should I expect during my sleep study?
While the patient is sleeping, various important body functions and data are being monitors and recorded. All the information gathered via the sensors are fed into the computer. The technician is monitoring the equipment throughout the duration of study in a separate room. Our technologists are experts in sleep recording procedures and will be happy to answer any questions you may have. Depending on your sleep study if a respiratory or breathing problem is observed during sleep the patient can be woken up to try a device that treats breathing problems. This device is a Continuous Positive Airway Pressure (CPAP), which includes a small mask that fits around the nose.

5) Will I need to take my medication's the night of my sleep study?
Yes. The patient should not discontinue any prescription medication without consulting his/her doctor first. It is however important that the patient write down in the questionnaire that she/he is given before the sleep study, any medication that he/she has been taking. If you are beginning a new medication that you have not taken for more than a week please let our technician know, to insure it does not affect your sleep pattern.

6) Are there any recommendations that I should follow on the day of my sleep study?
It is important that the patient's hair is thoroughly dry and free of oils or sprays for the study. We recommend that the patient not take any naps on the day of the study and should limit themselves to 2 caffeinated beverages (including coffee, tea, or soft drinks containing caffeine) 12 hours prior to the study. No alcoholic beverages should be consumed on the day of the study.

7) What should I expect after my sleep study?
About 5-business day after a sleep study the results will be compiled and forwarded to your physician. Your physician will then go over the results with you and make his/her recommendations. Please note that the technologist performing your sleep study will not have any information regarding your diagnosis.

COLLIN COUNTY SLEEP DIAGNOSTICS
Sleep Studies

DIAGNOSTIC STUDIES
During this sleep study, patient will undergo a comprehensive sleep study. Patient will be allowed to sleep in any position; however we would like to see patient on his/her back for some time (unless patient has a medical condition that would make it difficult to sleep on their back). This allows us to completely diagnose the patient for sleep apnea.

SPLIT NIGHT (CPAP) STUDIES
This sleep study consists of a diagnostic portion which observes for snoring as well as periods of "stopping of breathing", also known as sleep apnea. The second part of the night will entail treatment with either CPAP (Continuous Positive Airway Pressure) or BI-LEVEL (dual-level Positive Airway Pressure) using a nasal, intranasal, or full-face mask to treat the snoring as well as the sleep apnea. In this portion of the night patient is also allowed to sleep in any position. This allows us to diagnose and treat the patient in one night.

ALL NIGHT TREATMENT STUDIES
During this sleep study the patient will undergo a comprehensive sleep study with either CPAP (Continuous Positive Airway Pressure), or BI-LEVEL (dual-level Positive Airway Pressure). The patient will choose a nasal, intranasal, or full-face mask for this type of study. This sleep study is necessary if the patient has already had a diagnostic sleep study. A patient that is already on PAP therapy may be required by their insurance company to undergo this type of study in order to get new equipment or an updated prescription for supplies.

MULTIPLE SLEEP LATENCY TEST (MSLT)
This is a series of nap studies that are performed primarily during the day and followed after your sleep study. The first nap will begin generally 1.5 to 2 hours after patient is awakened from their sleep study with the following naps occurring two hours thereafter. These naps are "opportunities" for patient to sleep under quiet conditions with all lights in the room turned off. Some of the monitoring devices that were placed on patient for the sleep study will be removed. After these devices have been removed, patients are to change into their "daytime clothes". In between each nap patient is to remain awake and out of the bed. We will provide patient with breakfast and lunch during this study. Patients are not allowed to have any caffeinated beverages during the day. This is a standardized test to rule out Narcolepsy and/or Idiopathic Hypersomnolence; both of which are sleep disorders which can cause a patient to feel "excessively sleepy". Patient will undergo a urine drug analysis during this study and are included in patient's results.

MAINTENANCE OF WAKEFULNESS TEST (MWT)
This is a series of nap studies that are performed primarily during the day and followed after your sleep study. The first nap will begin generally 1.5 to 2 hours after patient is awakened from their sleep study with the following naps occurring two hours thereafter. These naps are "opportunities" for patient to "remain awake". Some of the monitoring devices that were placed on patient for the sleep study will be removed. After these devices have been removed, patients are to change into their "daytime clothes". Patient will either be sitting up in bed or sitting in a chair in a dark room and patient is to try to remain "awake" for a period of 40 minutes for each session. During this 40-minute period patient's are not allowed to stimulate in any manner (pinching self, singing, etc.). In between each session, patient is to stay out of the bed and try to remain awake. We will provide patient with breakfast and lunch. Patients are not allowed to have any caffeinated beverages during day of study. This is a standardized test to justify their level of alertness/wakefulness (for employment reasons).

PAP-NAP: Positive Airway Pressure (PAP) Nap is a daytime study for patients who have anxiety about starting PAP therapy, are claustrophobic, or having difficulty tolerating PAP therapy for their sleep-related breathing

disorder. The patient works one-on-one with a sleep technologist using relation, deep breathing and desensitization techniques to try to become more comfortable with PAP therapy.

Date of Study:_____

PATIENT INFORMATION

Patient Name_____DOB_____

SS#: _____ DL/ID NO: _____

Address_____City_____Zip_____

Tel #:_____Cell: _____

Email address_____

Male____ Female____ Single___ Married___ Divorced___ Widowed___

Employer_____

Employer Address_____

INSURANCE INFORMATION

Insurance Name_____ID#_____

If you are not the subscriber:
Name: _____DOB_____Relationship:_____

EMERGENCY CONTACT

Name_____ Tel #:_____ Relationship: _____

Patient authorizes payment of insurance benefits to be paid directly to Sleep Disorders Centers or agrees to forward and payments issued by his Insurance for services rendered to Sleep Disorders Centers.
Patient agrees to pay reasonable attorney fees and cost should a collection or suit be necessary to collect payments issued to patients by the Insurance and not forwarded to Collin County Sleep Diagnostics by Insured. Patient authorizes Collin County Sleep Diagnostics to release any information acquired in the course of the diagnostics and treatment to his physician and for collecting on unpaid services

Patient's Signature_____**Date**_____

If patient is a minor, Parent or Guardian's Signature_____

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Name: _____ **Date**: _____

Age _____Height: _____ Weight: _____ BMI (Kg/m2) _____ Neck Size _____

What is the reason for your sleep evaluation?

_____

Have you had a sleep problem in the past? _____

_____

What treatments were tried? _____

EXCESSIVE SLEEPINESS

Do you feel excessively sleepy during the daytime? If yes, how long? _____
Is this a result of your sleep?_____ _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, as compared to just feeling tired? Even if you have not done some of these things recently, try to answer how you think you would be affected.

Use the following scale: 0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance of dozing

Sitting and reading	_____
Watching TV	_____
Being inactive in a public place (theater, meeting, etc.)	_____
Sitting as a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon if 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 (**Epworth Score**)

Have you ever had an unexplained lapse of consciousness while driving? (reportable to Health Dept) _____

_____

Have you felt sudden muscle weakness when you laughed, got angry, surprised? _____

Have you ever been unable to move your body just as you were falling asleep or waking up?_____

Have you had hallucination or dreams apart from sleep?_____

Do you snore? ___ Never ___ Occasionally ___ Frequently ___ Always

Please circle "loudness" rating which best describes your **SNORING**

Patient's rating: (none) 0 1 2 3 4 5 6 7 8 9 10 (very loud and disturbing)
Bed partner rating (none) 0 1 2 3 4 5 6 7 8 9 10 (very loud and disturbing)

With your snoring, do you have any episodes of:

Yes/No **Choking/Gasping** Yes/No Episodes of stopped breathing
Yes/No Awakenings Yes/No A partner noting that you stopped breathing (**OBSERVED APNEA**)

Yes/No **MORNING HEADACHES**

SLEEP SCHEDULE AND SLEEP HYGIENE

What time do you usually go to bed and wake up on weekdays?_____
What time do you usually go to bed and wake up on weekends?_____
Yes/No Do you keep a regular sleep/wake schedule?
Yes/No Do you nap during the day Average length of nap? _____
Yes/No Do you read in bed?
Yes/No Do you worry in bed?
Yes/No Do you currently do shift or night work? If yes, what hours? _____
Yes/No Have you done shift work or night work in the past? If yes, do you have trouble sleeping when you do shift work? Yes/No

If you could set your own schedule, what time would you go to bed and when would you get up?_____

Name: _____ **Date**: _____

INSOMNIA

Yes/No Do you often have trouble getting to sleep? How long does it take?_____
Yes/No Do you wake up during the night? How many times per night you wake up? _____

Yes/No Do you have prolonged periods when you awaken and are unable to get back to sleep?_____

Yes/No Do you wake too early?
Yes/No Do you check the clock when you are unable to sleep?

MOVEMENT

Yes/No Do you kick your legs at night? Yes/No Do you have restless legs at night?

PARASOMNIAS

Yes/No Do you have nightmares or terrors? Yes/No Do you grind your teeth at night?

Yes/No Did you wet your bed as a child? Yes/No Do you sleepwalk?

MEDICATIONS AND DRUGS

Drug allergies _____

Please list the medications you are taking:

MEDICATION	DOSAGE	HOW OFTEN	CONDITION/REASON

Yes/No Do you smoke or use tobacco?
Yes/No Do you use caffeine? Please estimate the amount per day_____
Yes/No Do you use drugs or alcohol?_____

FAMILY AND MEDICAL HISTORY

Yes/No Do members of your family have any sleep problems?_____

Yes/No Have you had surgery on your nose or throat? _____

Do you have:

Yes/No	High blood pressure	Yes/No	Kidney disease	Yes/No	Seizures/Head trauma	Yes/No	Pneumonia
Yes/No	Low Blood pressure	Yes/No	Diabetes	Yes/No	Impaired Cognition	Yes/No	Tuberculosis
Yes/No	Lung disease	Yes/No	Stroke	Yes/No	Depression/Anxiety	Yes/No	Heart disease

Previous surgeries _____

_____

Hospitalizations or major illnesses _____

_____

_____

Psychiatric/Psychologic Therapy_____

Have you ever had a sleep study before? Yes/No Which Sleep Center? _____

Are you currently being treated for Sleep Apnea? Yes/No What is the Treatment? _____

Are you on CPAP/Bilevel or Oxygen? Yes/No What Therapy and Settings/LPM? _____

What Durable Medical Equipment Company Provided your Equipment? _____