Lexington Sleep Solutions

LexingtonSleepSolutions.com

PHYSICIAN OFFICE:
Lexington Medical Park 2, Suite 400
146 North Hospital Drive, West Columbia, SC 29169
(803) 936-7725 • **FAX:** (803) 254-5121

SLEEP LABS:
109 West Hospital Drive, West Columbia, SC 29169
(803) 791-2683 • **FAX:** (803) 739-0002

7043 St. Andrews Road, Columbia, SC 29212
(803) 791-2683 • **FAX:** (803) 781-0823

109 Barton Creek Court, Suite A, Columbia, SC 29229
(803) 791-2683 • **FAX:** (803) 719-8901

Clarence E. Coker III, MD

Sarkis S. Derderian, DO, FCCP

Paul M. Kirschenfeld, MD, FCCP

M. Christopher Marshall, MD, FCCP

Mohamed S. Soliman, MD, FCCP

Francis M. Dayrit, MD, FCCP

Patient Sleep History and Physical

Dear Patient,

We appreciate your selection of this office to serve your medical and health needs and we will do all we can to provide you with the very best care.

You must bring the following items with you to your appointment:

☐ **Completed Patient Information Form**

☐ **Completed Health History Form**

☐ **Insurance Card(s)**

☐ **All of your current medications**

Please do not wear perfume, cologne or scented lotion when visiting our office, as it can aggravate the breathing problems of others.

Your Appointment time is:

We look forward to seeing you and establishing a happy and healthy relationship. Please feel free to call with any questions regarding your upcoming visit.

Sincerely,
Lexington Sleep Solutions

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Patient Sleep History and Physical

Dear Patient _____

Welcome to Lexington Sleep Solutions.

Following are our policies as well as answers to many frequently asked questions. Please feel free to ask any of our staff questions that we have not covered.

Hours of Operation

Our office is open for patient appointments from Monday through Friday from 9:00 a.m. till 4:30 p.m. Our phones are answered 24 hours a day. During office hours, the phones are answered by our staff. After hours, they are answered by our answering service that will notify the physician on call if necessary. Please remember that calls after hours should be for emergencies only.

After-hours Phone Calls

Phone calls after hours should be for emergencies only. Routine phone calls such as prescription refills, appointment scheduling/rescheduling, billing questions, etc., should be made during regular business hours. Should you need to call after hours for routine reasons, we reserve the right to charge a $25.00 consultation fee.

Prescription Refills

Refills for prescription drugs should be handled during your visit with your physician. On occasion, you may need a refill prior to your next visit. We will be happy to take care of that on your behalf. We ask for a 24-hour notice for non-emergency refills. This will allow us to call your prescription to your pharmacist during less peak times during the day. Due to increasing costs of physicians and other staff, we reserve the right to charge for non-emergency refills with less than 24-hour notice or during non-office hours.

No-show Appointments

Failure to show up for a scheduled appointment without canceling within 24 hours could result in a charge for that appointment, and multiple no-show appointments could result in dismissal from our practice. We have reserved that appointment time for you and have other patients who, with advance notice, could be seen in your place.

Co-pays , Co-insurance and Deductibles

We currently participate with most of the insurance carriers. Participation means that we have signed contracts with the carriers who obligate our practice to follow certain rules and guidelines. One of those rules is that we collect co-pays, co-insurance and deductibles at the time of service. Failure to do this may result in the carrier reducing the amount they will pay us. For this reason, we must enforce collection of these fees at the time of service and not after your carrier processes your claim. We reserve the right to charge an additional fee if you do not pay your co-pay, co-insurance or deductible at the time of your visit.

Insurance Coverage

It is very important that you notify us of any changes in your insurance coverage either by phone or on the date of your visit. We must have your most recent coverage in order to help you to obtain reimbursement from your insurance carrier. We ask that you bring your insurance card and effective date of coverage with you on each visit so that we may obtain a copy.

Insurance and Patient Billing

As a service to our patients, we will send a claim to your primary and, if applicable, your secondary insurance carrier on your behalf. This does not relieve you of your responsibility to pay Lexington Sleep Solutions for the service we render to you. We will work with you to have your insurance carrier pay for any charges they should pay, but you are ultimately responsible to make sure we are paid for the treatment you receive. Those patients that have good knowledge of their insurance policy and coverage typically receive quicker reimbursement for covered services. Any outstanding insurance claims 45 days or older from the date of service will be reverted to your responsibility to pay. We will attempt to collect that balance and any other outstanding co-pays, co-insurance or deductibles for a period of 90 days and may then refer your account to an outside collection agency, which could result in you being discharged from the practice. PLEASE NOTE THAT WHEN YOU RECEIVE A BILL FROM OUR PRACTICE, WE ARE NO LONGER ATTEMPTING TO COLLECT THOSE CHARGES FROM YOUR INSURANCE CARRIER AND YOU ARE THEN RESPONSIBLE. SHOULD YOU FEEL THAT YOUR INSURANCE CARRIER HAS NOT PROCESSED A CLAIM, YOU SHOULD CALL THEM TO INQUIRE.

A detailed description of our Financial Policies is displayed in our lobby and check-out window for your review. We accept cash (including money orders and personal checks), and Visa/Master Card/Discover as payment for the service we render to you.

We hope we have been able to answer all your questions concerning our practice, but please feel free to ask any of our staff should you have other concerns.

Thank you for choosing Lexington Sleep Solutions for your medical needs. We know you have a choice, and we will do everything possible to earn and keep your trust in us.

I have read the information above and understand the policies and practices of Lexington Sleep Solutions.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

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Patient Sleep History and Physical

Name:_____

Age:_____ Date:_____ Referring Physician:_____

Please help us find out about you by filling out the "Patient" side of this form on pages 1-2. Please leave the "Clinician" side blank.

PATIENT	CLINICIAN

Why are you here to see a sleep specialist? (i.e. snoring, daytime sleepiness, other)

_____

_____

Have you ever had a sleep study?
If so, when?_____ And where? _____
Do you snore? ☐ Yes ☐ No ☐ I don't know ☐ Sometimes
How long ago did it start? _____
Is it worsening? ☐ Yes ☐ No
Has anyone ever noticed if you stop breathing? ☐ Yes ☐ No
Do you gasp or choke while you sleep? ☐ Yes ☐ No
Do you and your bed partner sleep in separate rooms because of your snoring?
☐ Yes ☐ No
Do you suffer from morning headaches? ☐ Yes ☐ No
Do you feel sleepy during the daytime? ☐ Yes ☐ No
Do you get up to go to the bathroom at night? ☐ Yes ☐ No
If so, how many times?_____
Have you gained any weight over the last year? ☐ Yes ☐ No
If so, how much?_____
Do you ever get sleepy driving? ☐ Yes ☐ No
Are there times when you have difficulty concentrating in the afternoon?
☐ Yes ☐ No
Do you suffer from memory problems? ☐ Yes ☐ No ☐ I don't know
Do you get irritable easily? ☐ Yes ☐ No
Do you take any daytime naps? ☐ Yes ☐ No
Do you ever experience restlessness or discomfort in your legs? ☐ Yes ☐ No
Do you move or kick your legs while sleeping? ☐ Yes ☐ No
Have you ever felt the sudden loss of strength (arms, legs) in response to some emotional experience? ☐ Yes ☐ No
Do you ever have bizarre dreams? ☐ Yes ☐ No
Have you ever lain in bed awake and felt paralyzed? ☐ Yes ☐ No
How likely are you to doze off or fall asleep? Please use the following scale:
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing

Tell us about your sleep schedule:

_____ sitting and reading
_____ watching television
_____ sitting inactive in a public place
_____ sitting and talking to someone
_____ while a passenger in a car without a break
_____ lying down to rest in the afternoon when circumstances permit
_____ sitting quietly after a lunch without alcohol
_____ in a car, while stopped in traffic for a few minutes

Epworth score:_____ **Date:**_____

PATIENT	CLINICAL
What is your bedtime?_____ What time do you get up?_____ How long does it take you to fall asleep?_____ Do you wake up in the middle of the night? ☐ Yes ☐ No How many times per night? _____ Do you fall asleep again easily? ☐ Yes ☐ No	

PAST MEDICAL HISTORY

Please check or list.

☐ Hypertension ☐ GERD ☐ Severe Arthritis ☐ Diabetes

☐ Heart Disease ☐ Fibromyalgia ☐ Asthma/COPD ☐ Lower Back Pain

☐ Other _____

Have you ever had any operations? Any injuries? _____

_____

Check if any close family member (parents, brothers and sisters, children) have:

☐ Sleep Apnea ☐ Heartburn ☐ High Blood Pressure ☐ Heart Problems ☐ Diabetes

Are there any other health problems in your family? _____

_____

SOCIAL HISTORY

With whom do you live?_____

What is your occupation?_____

Do you smoke? ☐ Yes ☐ No

How long? _____ How much?_____

Have you quit? ☐ Yes ☐ No If so, when?_____

Do you drink alcohol? ☐ Yes ☐ No

How long? _____ How much?_____

Have you quit? ☐ Yes ☐ No If so, when?_____

Do you drink caffeinated beverages? ☐ Yes ☐ No How much?_____

Do you take any medications at bedtime? ☐ Yes ☐ No

If so, what and how much?_____

_____

REVIEW OF SYMPTOMS (Please circle any symptom you have, so we can find out more about it)

Eye problems	such as double or blurred vision; glaucoma; cataracts	**HEENT**
Hearing problems	buzzing or ringing in ears	
Allergies; hay fever; Sinus problems		
Blood pressure or heart problems		
Asthma; tuberculosis; emphysema; chronic bronchitis		**Cardiac**
Stomach problems	heartburn; indigestion; change in bowel habits	**Pulmonary**
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones		**Digestive**
Urinary problems	frequency; infections; stones; bladder; bed wetting Men: prostate problems; night-time urination Women: abnormal menstrual periods; could you be pregnant	**Urinary**
Joint pains	swelling or redness; arthritis; back pain	**Musculoskeletal**
Muscle aches or tenderness; gout; arthritis		
Rash, itching or other skin problems		**Dermatological**
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam		**Reproductive**
Paralysis (even temporary); stroke; numbness; loss of balance		**Neurological**
Seizures; loss of memory; headaches		
Unusual thoughts; nervousness; crying or sadness; depression		**Psychiatric**
Thyroid disorder; diabetes; excess thirst; excess hunger or urination		**Endocrinology**
Bleeding; easy bruising; risk factors for HIV; anemia; cancer		**Hematological**