Harbor View
MEDICAL SERVICES, PC
A proud member of Mather Hospital/Northwell Health

Mather Hospital
Northwell Health®

Mather Pulmonary and Sleep Associates

Medical Arts Building
625 Belle Terre Road • Port Jefferson, NY 11777
Phone: 631.476.2721 Fax: 631.476.2772

Patient's Name: _____

Appointment Date: _____ **Time:** _____

This is confirmation of your appointment with Dr. _____

Enclosed you will find a packet of papers. On the day of your appointment, please bring all of the following:

- The completed packet of paperwork
- Insurance Card(s)
- License or Photo ID
- Any referrals ***(if required by your insurance company)***

Please call within 48 hours if you cannot make this appointment.
There is a $25 charge for any and all missed appointments.

Directions to the office and arrival instructions:

Sleep Disorders Center

Mather Hospital

Frey Family Foundation Medical Arts Building

625 Belle Terre Road

Port Jefferson, NY 11777

•1st. Floor•

Park in the Medical Arts Building parking lot.

Upon arrival, please remain in your vehicle and call 631.476.2721 - Option 2 - for further instructions.

Please Note

Due to a variety of insurance plans that are now available to patients (especially PPO, POS, etc.), you are advised to call your insurance company and confirm your potential financial responsibility.

If you have a sleep study done, it may be required for you to stay over for 1 or 2 nights. This is an outpatient procedure and there might be coinsurance or co-payment due.

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Patient Label

PATIENT REGISTRATION

Date: _____

IDENTIFICATION

Last Name: _____ First Name: _____ Middle Initial: _____

Previous Name (If applicable) Last: _____ First: _____

Legal Sex: (check one) ☐ MALE ☐ FEMALE Date of Birth: _____/ _____ /_____

CONTACT

Address (# and Street): _____

Address (continued): _____

Zip Code: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Consent to text: ☐ YES ☐ NO

Email: _____

Contact Preference: ☐ HOME ☐ CELL ☐ EMAIL (should have a back-up phone number)

DEMOGRAPHICS

Primary Language: _____ Second Language: (if applicable) _____

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: (check one) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Multiracial ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Another Race

Marital Status: (check one) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMERGENCY

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

Next of Kin

Name: _____ Relationship: _____

Home Phone: _____ Mobile Phone: _____

EMPLOYMENT

Employer Name: _____

Employer Phone: _____

Occupation (Current or Most Recent): _____

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Patient Label

Health Insurance Portability and Accountability Act *(HIPAA)*

Patient Name: _____ Date: _____

This form contains how your Protected Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations.

Please review the following questions, indicating any restrictions

- I agree that the office has the right to call my home or place of employment regarding appointment and/or insurance issues.

☐ Yes ☐ No Restrictions: _____

- I give permission to the office to call me and/or leave messages for me on an answering machine/voice mail.

☐ Yes ☐ No Restrictions: _____

Other than myself, I authorize the physician(s)/practitioner(s) of Harbor View Medical Services, PC to share/discuss my medical information with:

1. Name:_____ Relationship: _____ Phone: _____

2. Name:_____ Relationship: _____ Phone: _____

3. Name:_____ Relationship: _____ Phone: _____

- I understand and agree to allow Harbor View Medical Services, PC to use my PHI for the purpose of treatment, payment, healthcare operations and coordination of care.
- I have the right to my exam and to obtain a copy of my own health records at any time, and request corrections. I may request the disclosures that have been made and submit in writing any further restrictions on the use of my PHI. Our office is not obligated to agree to those restrictions.
- A patient's written consent need only be obtained one time for all subsequent care given at this office.
- I may provide a written request to revoke consent at time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any change given after the request has been presented.
- For your security and right to privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Harbor View Medical Services, PC to assure that your records are not readily available to those who do not need them.
- I understand that incidental disclosures of my PHI may be made. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- I have the right to file a formal complaint with the privacy official about any possible violations of the policies and procedures.
- If I refuse to sign this consent for the purpose of treatment, payment and healthcare operations has the right to refuse care.

Signed: _____ Date: _____

Signature of Patient or Legal Representative

If signed by legal representative, please indicate the relationship:_____

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Patient Label

Assignment of Benefits

Patient Name: _____ Date: _____

1. I authorize, assign, and direct my insurance carrier to pay directly to Harbor View Medical Services, PC, dba Mather Primary Care, for services rendered to me, now or hereafter, which are payable under my insurance contract or contractual agreement.

2. I agree that in the event that I receive checks, drafts or other payment subject to this agreement, I will act as fiduciary agent to the office. The office agrees to apply any proceeds to my debt for services rendered.

3. I fully understand and agree that the insurance policies are an arrangement between the insurance carrier and me. I will be responsible for expenses not paid by the insurance carrier. I also understand that I am responsible for any referrals required by my insurance carrier.

4. I understand that the provider is legally obligated to collect all copays, deductibles and/or coinsurance deemed to be the patient/insured responsibility by the insurance company. (NOTE: Some insurance carriers require and additional copay/coinsurance for tests performed during an office visit. IF so, you will be billed for this after the claim has been processed and we have been so instructed by the insurance carrier of your additional responsibility.)

5. I understand that I must provide all information required for my WORKER'S COMPENSATION/NO FAULT insurance or I will be responsible for the expenses incurred.

☐ NOT APPLICABLE ☐ INFORMATION PROVIDED

6. I understand that, if necessary, the office may employ collection counsel and/or an attorney on my bill, I will be responsible for any said collection and/or attorney fees.

I acknowledge that I have read, or have had read to me, the above information. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below, I agree to the above mentioned statements.

Signed: _____ Date: _____

Signature of patient or Legal Representative

If signed by a legal representative, please indicate the relationship: _____

Northwell Health®

Patient Label

Mather Pulmonary and Sleep Associates

Acknowledgement of Receipt

I have received a copy of the Provider's Notice of Privacy Practices.

Patient/Agent/Relative/Guardian* (Signature)	Date / Time	Print Name	Relationship if other than patient

Telephonic Interpreter's ID #	Date / Time

OR

Signature: Interpreter	Date / Time	Print: Interpreter's Name and Relationship to Patient	
Witness to signature (Signature)	Date / Time	Print Witness Name	

PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

Signature	Date / Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Mather Hospital Northwell Health® • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

SD5380

Patient Name:_____
Male_____ Female_____ Age Date of Birth:_____
Height _____ Weight _____ Neck Size _____ inches

Primary Care Physician:_____ Referring Physician:_____

1. Please describe your sleep problems in your own words. Please be as detailed as possible.
   a. _____
   b. _____
   c. _____
   d. _____

2. How long have you had your sleep problem?_____
3. Have you or your partner noted loud snoring or abnormal breathing during sleep?
   _____ Yes _____ No
4. Do you have frequent difficulty concentrating or have lapses in attention due to drowsiness?
   _____ Yes _____ No
5. Do you take naps during the day? _____ Yes _____ No
   i. If yes, how long? _____
   ii. Do you awaken refreshed? _____ Yes _____ No
6. What time do you get into bed?_____
7. How long does it take you to fall asleep after lights out?_____
8. Do you awaken during the night? _____ Yes _____ No
   i. If yes, how many times? _____
   ii. Do you get out of bed? _____ Yes _____ No
   iii. Do you stay in bed trying to get back to sleep? _____ Yes _____ No
   iv. How long does it take for you to fall back asleep?_____
   v. What do you do in the meantime?_____
9. What time do you arise in the morning?
   i. Weekdays (Work days) _____ Weekends (Days off) _____
   ii. Do you feel more refreshed when you sleep in? _____ Yes _____ No
10. Do you awaken refreshed?_____ Yes _____ No
    i. Tired and groggy? _____ Yes _____ No
    ii. With headaches? _____ Yes _____ No
11. Were you a good sleeper prior to your sleep problem?_____ Yes _____ No
12. Were you ever unable to more your arms and legs upon awakening?
    _____ Yes _____ No

13. Do you become weak in the knees with laughter or strong emotion?
    _____ Yes _____ No
14. Do you feel sleepy while driving?
    Always _____ Sometimes _____ Rarely _____ Never_____
15. Have you ever walked in your sleep? _____ Yes _____ No
16. Are you a restless sleeper, thrash, or kick? _____ Yes _____ No
17. Have you gained or lost significant weight over the last year?_____ Yes _____ No
18. Do you get tingling, weakness, cramps, twitches, or other "funny" feelings in your legs that make you keep moving or flexing them and prevent you from sleeping or relaxing?
    _____ Yes _____ No
19. Were you ever knocked unconscious, or suffered a major head injury?
    _____ Yes _____ No
20. Have you ever had a major infection of the central nervous system (meningitis, encephalitis, etc)?
____ _____ Yes _____ No
21. Please list all the medications dose and frequency you are currently taking, or took in the last 3 months:

    _____

    _____

    _____

22. Does anyone in your family snore or have been told they have Sleep Apnea?
    If yes, relationship _____
23. Have you ever bee told that you have: ***Circle all that apply:***

High Blood Pressure	Diabetes	Allergic Sinusitis	Deviated Nasal Septum
Asthma COPD	Neuropathy	Thyroid Condition	Seizures or Epilepsy
Heart Condition	Depression	Acid Reflux (GERD)	Psychiatric Disturbances

    Other:

    _____

24. Please list all allergies (pollen/dust), drug allergies, or any other medical facts that you may feel are important?

    _____

    _____

    _____

25. Have your tonsils ever been removed?_____
26. Is your nose constantly running or frequently congested?_____
27. Present occupations and working hours:_____
28. **My major problem(s)** ***Check all that apply:***

_____ Sever daytime drowsiness
_____ Difficulty falling or staying asleep
_____ Problems breathing at night or snoring
_____ Doing unusual things in my sleep (i.e. sleep walking, night terrors, night sweats, bed wetting, screaming, etc.)
_____ Other (please explain)

29. Please rate your likelihood to fall asleep under the following conditions?
    (0 = Never, 1 = Slight, 2 = Moderate, 3 = Severe)
    i. Sitting and reading _____
    ii. Watching TV _____
    iii. Sitting inactive in a public place _____
    iv. As a passenger in a car for at least an hour without a break _____
    v. Lying down in the afternoon, when circumstances permit _____
    vi. Sitting and talking to someone _____
    vii. Sitting quietly after lunch without alcohol _____
    i. In a car, while stopped for a few minutes in traffic _____
30. Are you presently under unusual stress at home? _____ Yes _____ No
    At work? _____ Yes _____ No
31. What medications do you take to help you fall asleep?

    _____

    _____
32. Do you ever have a dream like (visual) experiences after wakening?
    _____ Yes _____ No
33. Do you remember your dreams?
    i. Usually _____ Rarely _____ Never_____
    ii. Are they usually: Non-frightening _____ Frightening_____
34. Are they vivid? _____ Yes _____ No
    Only small fragments? _____ Yes _____ No
35. How many cups of caffeineated beverages do you consume daily?_____
36. How much alcohol do you consume daily? (please be specific)

    _____
37. How much do you smoke? _____
38. Do you need assistance to be mobile?_____ Yes _____ No
39. Do you need assistance to the bathroom? _____ Yes _____ No
40. Do you have any special needs that we should be aware of?
    a. _____
    b. _____
    c. _____
    d. _____

Person completing interview _____

Date: _____ Time: _____