

MICHELLE ZETOONY, DO, FCCP, FACOI DO SLEEP SOLUTIONS

Account# _____

PATIENT INFORMATION

Patient Name: _____		DOB: ____/____/____	SS#: ____-____-____	Sex: Male ___ Female ___
Address: _____		City: _____	State: _____	Zip: _____
Phone#: (____) _____	Cell# (____) _____		<input type="checkbox"/> Check this box if we may use this cell # for text and/or robocall <u>appointment reminders</u>	
Email: _____				
Nationality: <input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White				
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Declined				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Seperated <input type="checkbox"/> Partnership				
Primary Care Provider: _____		Primary Care Provider's Phone: (____) _____-_____		
Pharmacy: _____	Pharmacy Phone: (____) _____-_____	Pharmacy Cross Streets: _____		
Smoker? <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked				
Primary Language: _____	Preferred method of contact: Email Phone Cell Phone Text (Please Circle One)			
Whom may we thank for referring you: _____				
Employer Status: <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed <input type="checkbox"/> Student				
Occupation: _____		Employer _____		
Employer Address _____		Work Phone: (____) _____		

EMERGENCY CONTACTS

#1. Name: _____	Relationship: _____	Phone#: (____) _____-_____
#2. Name: _____	Relationship: _____	Phone#: (____) _____-_____

INSURANCE INFORMATION

Primary Insurance Carrier: _____	Policy# _____	Group# _____
Policyholder's Name: _____	Date of Birth _____	
Policyholder's SS#:: _____	Relationship to patient: _____	
Claims Address: _____	City: _____	State: _____ Zip: _____
Eligibility Phone# (____) _____-_____		
Secondary Insurance Carrier: _____	Policy# _____	Group# _____
Policyholder's Name: _____	Date of Birth _____	
Policyholder's SS#:: _____	Relationship to patient: _____	
Claims Address: _____	City: _____	State: _____ Zip: _____
Eligibility Phone# (____) _____-_____		

MICHELLE ZETOONY, DO, FCCP, FACOI

REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician. DO Sleep Solutions, Inc., has the right to refuse to you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Patient Signature _____ Date _____

ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to DO Sleep Solutions, Inc., for any medical services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made

Patient Signature _____ Date _____

OFFICE POLICY FOR PAYMENT

Payment is expected IN FULL at the time services are rendered by the patient or the person accompanying the minor child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier. I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection, including filing fees as well as reasonable attorney's fee.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient Signature _____ Date _____

Health Insurance Portability and Accountability Act

What is HIPAA?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

- Provides the ability the transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information

I have been offered or received a copy of the HIPAA form by DO Sleep Solutions, Inc. I have been asked to review the information and given opportunity to ask questions if i am unclear about the meaning of the information.

Patient Name

Date

E-medication History Download

The Medication History service allows prescribers and pharmacies to use the Surescripts network to access a patient's Medication History across provider, at the point of care. This service can be used in the course of providing routine care, as well as during emergencies (like natural disasters). In both cases, Medication History enables healthcare providers to make a more informed clinical decision. To provide this service, Surescripts security connects to a patient's medication history data stored in the database of community pharmacies and pharmacy benefit managers. Surescripts requires patient consent as part of the process a prescriber must go through each each time they electronically access a patient's medication history. If a request for medication history is sent to Surescripts and the patient consent flag is not set, Surescripts rejects the request.

I hereby provide DO Sleep Solutions, Inc., the ability to download my complete Medication History from the nationwide database of pharmacies.

Patient Name

Date

MICHELLE ZETOONY, D.O., F.C.C.P., F.A.C.O.I.
PATIENT MEDICAL HISTORY

Date: ___/___/___

Patient Name: _____ Gender: M F DOB: _____ Age: _____

Height: _____ Weight: _____

Past Medical History (Please answer all questions to the best of your ability):

Do you now or have you ever had:

	Yes	No		Yes	No
Tuberculosis (TB)			Thyroid disease		
Cancer			Stomach disease (includes ulcers acid reflux)		
High blood pressure			Intestinal disease		
Diabetes (blood sugar high or low)			Liver disease		
Heart Attack			Seizures		
Kidney Disease			Urinary issues		
Lung Disease			Other:		

Please explain all "Yes" answers:

Habits:

Do you know or have ever used:
 appt.)

- 1.) Tobacco (cigarettes, chew, pipes, etc.) Y N
 If yes, how long? _____ years. Quit? Y N
- 2.) Alcohol (beer, liquor, wine, etc.) Y N
 If yes, How long? _____ years. Quit? Y N
- 3.) Caffeinated beverages (soda, coffee, tea, energy drinks, etc.) Y N
 How many per day? _____
- 4.) Illicit drugs (injected, inhaled, other, etc.) Y N
 If yes, how long? _____ years. Quit? Y N

Medications: Please list all medications you are currently taking including over the counter. (you can bring packages/bottles to

- 1.)
- 2.)
- 3.)
- 4.)
- 5.)
- 6.)
- 7.)
- 8.)
- 9.)
- 10.)
- 11.)
- 12.)
- 13.)
- 14.)
- 15.)
- 16.)
- 17.)
- 18.)
- 19.)
- 20.)

Medication Allergies and reaction:

- 1.)
- 2.)
- 3.)
- 4.)
- 5.)

Food or environmental allergies:

- 1.)
- 2.)
- 3.)
- 4.)
- 5.)

Prior surgeries and dates:

- 1.)
- 2.)
- 3.)
- 4.)
- 5.)

Michelle Zetony, D.O., FCCP, FACOI

THE EPWORTH SLEEPINESS SCALE

Name _____

Date _____

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO JUST FEELING TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO WORK OUT HOW THEY WOULD AFFECT YOU. USE THE FOLLOWING SCALE TO CHOOSE **THE MOST APPROPRIATE** NUMBER FOR EACH SITUATION.

0=WOULD NEVER DOZE

1=SLIGHT CHANCE OF DOZING

2=MODERATE CHANCE OF DOZING

3=HIGH CHANCE OF DOZING

SITUATION	CHANCE OF DOZING			
1. SITTING AND READING	0	1	2	3
2. WATCHING TELEVISION	0	1	2	3
3. SITTING INACTIVE IN A PUBLIC PLACE	0	1	2	3
4. AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK	0	1	2	3
5. LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT	0	1	2	3
6. SITTING AND TALKING TO SOMEONE	0	1	2	3
7. SITTING QUIETLY AFTER LUNCH WITHOU ALCOHOL	0	1	2	3
8. IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	0	1	2	3

TOTAL _____

DO SLEEP SOLUTIONS, Inc.
Michelle Zetoony, DO

A good sleep is important to your well-being. Since most people spend roughly one-third of their lives asleep, it's easy to see how the quality of sleep directly affects the quality of your life. 1 in 3 Americans has a sleep disorder which makes sleeping or waking hours miserable. Many of these people suffer needlessly because they are unaware that a problem exists. Once detected, most sleep disorders can be corrected. **If you have experienced any of the following symptoms in the last year, check the box YES. When referring to night, assume that this means during sleep.**

Section 1:	YES	NO
1. I have difficulty falling asleep.		
2. Thoughts race through my mind and this prevents me from sleeping.		
3. I feel afraid to go to sleep.		
4. I wake up during the night and have trouble falling back asleep.		
5. I worry about things and have trouble relaxing.		
6. I wake up earlier in the morning than I would like.		
7. I lie awake for 30 minute or more before I fall asleep.		
8. I feel sad and depressed.		
Section 2:	YES	NO
9. I have been told that I snore.		
10. I have been told that I stop breathing sometimes when I sleep.		
11. I have been told my blood pressure is high.		
12. I have been told by friends/family that my personality has changed.		
13. I am gaining weight.		
14. I feel that I sweat more than I should at night.		
15. I have notice my heart pounding during the night.		
16. I get morning headaches.		
17. I have trouble sleeping when I have a cold.		
18. I wake up suddenly some night gasping for breath.		
19. I am overweight.		
20. I am losing my sex drive.		
21. I feel sleepy during the day even when I sleep through the night.		
Section 3:	YES	NO
22. I have a chronic cough.		
23. I have to use antacids (Tums, Alka-Seltzer, etc) at least once a week for stomach trouble.		
24. I have morning hoarseness or get sore throats.		
25. I wake up night coughing or wheezing.		
26. I wake up at night needing to catch my breath or with chest pain.		

NAME: _____ Date: _____

NAME: _____

DOB _____

Section 4:	YES	NO
27. I have had trouble concentrating in school/work.		
28. When I am angry or surprised, I feel like I'm going limp.		
29. I have fallen asleep while driving.		
30. I feel like I go around in a daze.		
31. I have experienced vivid dream-like scenes upon falling asleep/waking.		
32. I have fallen asleep during physical effort (eating meal, exercise, etc).		
33. I feel like I am hallucinating when I fall asleep.		
34. I like to cram a full day into every hour to get everything done.		
35. I have fallen asleep when laughing or crying.		
36. No matter how hard I try to stay awake, I fall asleep anyway.		
37. I sometimes feel like I am unable to move waking up or falling asleep.		
Section 5	YES	NO
38. Other than when exercising, I still experience muscle tension in my legs.		
39. I have noticed (or others comment) that parts of my body jerk.		
40. I have been told that I kick at night.		
41. I experience aching/"crawling" sensations in my legs.		
42. I experience leg pain during the night.		
43. Sometimes I can't keep my legs still at night. I just have to move them.		
44. I awaken with sore or achy muscles.		

Questions about your habits:

WEEKDAY: BEDTIME: _____

WAKE UP: _____

NAPS: _____

WEEKEND: BEDTIME: _____

WAKE UP: _____

NAPS: _____

WORK HOURS:

I WORK SHIFTS: YES NO

Please provide the information for the following procedures if they apply.

~Chest X-ray/CT? Y N
If yes, where and when. _____

~Pulmonary function test/Spirometry/ 6MW? Y N
If yes, where and when. _____

~Sleep studies (in lab or home)? Y N
If yes, where and when. _____

**If you are currently using a BIPAP/ CPAP machine please bring your COMPLIANCE DOWNLOAD CARD to your appointment.

Are you currently affiliated with a Durable Medical Equipment company? If yes, please provide the name. _____

Cancellation/ No show Policy

The cancellation/ no show policy is a courtesy to our office and patients. Cancelling or rescheduling an appointment **MUST** be done **24 hour prior** to your appointment time. Per office policy no show/ no call appointments and appointments not rescheduled 24 hour prior are subject to \$50 fee. Do sleep Solutions reserves the right to decline any future appointments after two occurrences if no payment arrangements have been made.

Notice

Please be courteous to the office and it's patient and arrive promptly at your scheduled appointment time. Appointments that are more than 10 min late are subject to be rescheduled.

Thank you for your understanding!

~DO Sleep Solutions Staff

****Please print, sign and date below acknowledging you understand the guidelines of this policy. ****

Print Name: _____

Signature: _____ Date: _____

The Doctor requests that patients obtain **all records** relevant to their appointment with her. This information may be brought with you or faxed to the office prior to your appointment. **It is the patient's responsibility to provide these records.** Failure to provide these records may necessitate re-scheduling the appointment.

INSTRUCTIONS: Please complete and sign this authorization and forward it to the appropriate facility to obtain records.

Thank you!

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:

- Record Requested:
- All sleep study reports
 - All PFT/ Spirometry/ 6MW
 - All imaging(Chest X-Ray, CT, ultrasound, etc.)
 - All offices notes prior to procedures
 - Other: _____

I hereby authorize to you to release my medical records. I understand my records may contain information about drug or alcohol abuse, communicable diseases, HIV testing or results and psychiatric or pschological conditions.

Release Record To: **DO SLEEP SOLUTIONS, Inc.**
Michelle Zetoony, D.O.
SOUTH Office NORTH Office
545 4th Ave S, Suite A 1831 N Belcher Rd, Suite E1
St. Pete, FL 33701 Clearwater, FL 33765
Phone: 727-826-0933 Fax: 727-826-0744

Other:

Patient name (PRINT): _____ Date: _____

Social Security #: _____ Date of birth: _____

PATIENT SIGNATURE (over age 18): _____

PERSONAL REPRESENTATIVE NAME & SIGNATURE: _____