Louisiana
Sleep
Foundation, LLC

4660 Bluebonnet Blvd., Baton Rouge, LA 70809 ph: 225-767-8550 – fax: 225-767-8556

Information needed for your appointment:

- Please print and fill out the attached forms and bring to your appointment.
- Copy of your insurance card and driver's license. Your co-pay will be collected at the time of your visit.
- List of any medications that you are currently taking with the dosage and # of times per day you take them.
- **If you have had any sleep studies done before, bring a copy of them with you to your office visit. If you are on a CPAP, bring your machine with you to your office visit.**
- This is a daytime clinic appointment to be evaluated by the provider and your appointment will last approximately 1 hour.
- If you are more than 15 minutes late to your appointment you will have to reschedule.

Directions to our office from I-10:

- Our facility is located at 4660 Bluebonnet Blvd. (near Jefferson Hwy).
- Exit I-10 North on Bluebonnet (away from the Mall of Louisiana).
- Go underneath the overpass of I-10.
- Cross over Blue Cross, Gail and Oliphant Street.
- Take the 1st U-turn once you've crossed Oliphant Street.
- Once you've made the U-turn, pull in to the 1st driveway on the right.
- Enter through the front of the building.

Directions to our office from I-12/Airline Hwy:

- Our facility is located at 4660 Bluebonnet Blvd. (near Jefferson Hwy).
- Exit Airline Hwy. South toward Gonzales.
- Take a right at the 2nd light on Bluebonnet Blvd.
- Traveling South on Bluebonnet (towards Mall of Louisiana) cross over Jefferson Hwy and take a right into the 7th driveway.

Louisiana Sleep Foundation, LLC

Full Name: _____SSN_____Date: _____

Phone_____Alternative_____ Date Of Birth:_____Race:___Gender:___

Address: *(Street, City, State, Zip)* _____

Insured Employer:_____ Who Referred You? O-Self O- Physician_____

Emergency Contact: _____ Phone: _____Marital Status_____

Have you ever had a sleep study? Where & When? _____How did you hear about us?_____

Symptoms: *(Please place a check next to all that apply)* *Height*_____ *Weight*_____

Consistent Symptoms

	Snoring interrupted by silence/absence of breath*
	Restless Sleep
	Loss of Energy
	Irritability / Short Temper
	Anxiety / Depression
	Trouble Concentrating
	Heavy Snoring
	Forgetfulness
	Mood / Behaviors
	Decreased Sex Drive
	Daytime Drowsiness*

Symptoms While Sleeping

	Tossing and turning in your sleep
	Heartburn
	Pain
	Sore Throat
	Falling Out of Bed
	Irresistible Urge to Move Legs
	Night Sweats
	Swelling of the Legs
	Bed Wetting
	Sour Belches
	Leg Jerking

Current Medications: *(Please list medications and dosage)*

_____

_____

Medication Allergies: *(Please list all medication and food allergies)*

_____

Medical History: *(Please place a check next to all that apply)*

	Cardiac		Stroke		Thyroid Problems*
	High Blood Pressure		High Cholesterol		Alcohol Use- _____
	Lung Problems		Gastrointestinal		Caffeine Use- _____
	Diabetes		Poor Circulation		Tobacco Use- _____
	Kidney or Liver Problems		Psychological Difficulties		Other _____

Family History: *(Please list your family's history of any medical problems)*

_____

Surgical, Procedure, Major Injury, and Hospitalization History: *(Please list and include the year)*

_____

Patient Signature _____ Time _____ LSF Staff Member Signature _____ Time _____

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New Patient Sleep Study Questionnaire

Patient Name:_____Date of Birth:_____

1. Have you ever had an in lab or HST before? YES NO

   If yes, what is the name of the facility: _____
   Address of facility: _____
   Phone Number of facility: _____
   Fax Number of facility: _____

2. When was your sleep study? _____

3. What is the name of the Physician that referred you for your sleep study?

   Referring Physician: _____
   Phone Number: _____
   Fax Number: _____

4. What is the name of your current Primary Care Physician?

   Primary Physician: _____
   Phone Number: _____
   Fax Number: _____

5. Are you currently using a CPAP/ BIPAP or AutoSV unit? YES NO

   If yes, what is the name of your DME supplier? _____
   Phone Number of supplier: _____
   Fax Number of supplier: _____

***If you have a CPAP/ BIPAP or AutoSV make sure to bring it with you to every office visit. Thank you!

Louisiana Sleep Foundation, LLC

Authorization Form

Release of Information

Louisiana Sleep Foundation, LLC is hereby authorized to release information relative to my illness (including any resulting effect it has had on my family life and financial situation) to my insurance company and any physicians, medical facilities, or community agencies which may potentially offer me assistance.

Obtaining Information

I hereby request and authorize you to furnish Louisiana Sleep Foundation, LLC any and all information you have concerning me in connection with any illness, condition, or injury, including medical history, consultations, prescriptions, treatment, x-rays, and/or copies of any and all hospital or medical records which you have pertaining to me. A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization is valid until revoked in writing by me.

Insurance

I hereby authorize Louisiana Sleep Foundation, LLC to furnish information to insurance carriers and doctor's offices concerning my illness and treatments. This signature also authorizes you to give me reasonable care by today's standards. I understand that I am responsible for all fees, regardless of my insurance coverage. In order to expedite insurance company payments, the necessary forms will be completed by this office. It is customary to pay for services when rendered unless other arrangements have been made in advance. I will also be responsible for any legal or other costs incurred in the collections on this account.

Financial Responsibility

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Louisiana Sleep Foundation, LLC for any services furnished to me by these providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for charges at all times.

HIPPA Policy

I understand any and all of my health information will be kept confidential at Louisiana Sleep Foundation, LLC. I have read and carefully reviewed the HIPPA Policy at Louisiana Sleep Foundation, LLC and agree with the terms.

Disclosure of Financial Interest

This disclosure is made by: J. Kyle Schwab, M.D., located at 4660 Bluebonnet Blvd., Baton Rouge, LA 70809, telephone number 225.767.8550; and William Hunter Hardin, N.P. located at 4660 Bluebonnet Blvd., Baton Rouge, LA 70809, telephone number 225.767.8550; (hereinafter collectively referred to as ("Healthcare Providers")

Healthcare Providers are the sole, equal shareholders within Louisiana Sleep Foundation, LLC. ("LSF"), which you (or the patient for whom you are the legal representative) are being referred to by a sleep study or related procedure. LSF is located at 4660 Bluebonnet Blvd, Baton Rouge, LA 70809.

You are not required to utilize LSF for these services. These services are available elsewhere in the community. This office will provide an alternative referral upon your request.

Patient Acknowledgement

I, the named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

Telemedicine

Louisiana Sleep Foundation, LLC is hereby authorized to contact me to conduct my visit via Telemedicine. I understand there will be a charge associated with this form of visit and I am financially responsible. I choose to decline Telemedicine._____
Patient Initials

_____	_____	_____	_____
Print Full Name	Signature	Date	Time

If you are not the patient, please state your relationship to the patient: _____

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Louisiana Sleep Foundation, LLC

Date: _____

First Name: _____ Last Name: _____

Preferred Email address: _____ ☐ Do not have an email address

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, how would they affect you? Use the following scale to choose the most appropriate number for each.

Answers: **0** = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Sitting and Reading	
Watching TV	
Sitting, inactive in a public place	
As a passenger in a car for an hour without a break	

Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Epworth Score _____

Louisiana Sleep Foundation, LLC
Authorization to Release Health Information

Patient Name	Date of Birth
Telephone	Social Security

Other Names Patient has used

All my Physician(s) and Organization(s) are authorized to provide my Patient Health Information to: Louisiana Sleep Foundation, LLC

J. Kyle Schwab, MD
4660 Bluebonnet Blvd.
Baton Rouge, LA 70809
Phone: (225) 767-8550
Fax: (225) 767-8556

I do authorize my complete health record to be faxed to 225-767-8556 or mailed to the address above. This information is being disclosed for the purpose of Continuing Health Care.

I understand that specific information to be released may include AIDS or HIV, Alcohol and /or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicates, this authorization will expire one year from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

Signature of Patient or Legal Representative	Relationship to Patient	Date