Pinehurst Medical Clinic

Location: «ApptLocDesc»
Pinehurst Medical Clinic Sleep Disorder Center
245 Page Road, Pinehurst, NC 28374

RE: Appointment Date: «ApptDate»
Appointment Time: «ApptTime»
Provider: «ApptResName»

«PFirst» «PLast»
«PStreet1»
«PCity», «PState» «PZipCode»

Dear «PFirst» «PLast»,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic's Sleep Disorder Center. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.
2. Bring your medical insurance card(s) and medications with you on the day of your appointment. To find a list of PMC's contracted payers or to review additional insurance information, please visit pinehurstmedical.com/resources-category/insurance
3. If previous medical records are needed our office may contact you to make arrangements to obtain records.
4. If you are a new patient being seen for Sleep Medicine and have seen a previous doctor for sleep issues, please bring all sleep records and studies you have had in the past to your appointment. You can also have these records faxed prior to your appointment by sending them to (919) 292-1205.
5. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

Pinehurst Medical Clinic Pulmonology & Sleep Medicine kindly ask you and anyone coming with you to your appointment to ***refrain*** *from wearing scented lotions, perfumes, and/or cologne as many of our patients are sensitive to these products. If you or any persons with you do not adhere to this policy, you may be asked to reschedule.*

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Sleep Medicine
(919) 292-1201

Pinehurst Medical Clinic

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	**State:**	**Zip Code:**
Home Phone:		
Mobile Phone:	**Other Phone:**	
Patient e-mail:		
Date of Birth:	**Sex:** □ Male □ Female	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Unknown		
Race: □ Black/African American □ Asian □ White □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Unknown		
Ethnicity: □ Hispanic □ Non-Hispanic		
Primary Language: □ English □ Spanish □ Other: _____		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: □ Employed □ Self-employed □ Retired □ Disabled □ Student □ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	**State:**	**Zip Code:**
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	**Effective Date – From:**
Subscriber Name:	**Patient's Relationship to Insured:**
Subscriber SSN:	**Subscriber's DOB:**
Subscriber Employer:	**Subscriber's Sex:** □ Male □ Female

Please Arrive 15 Minutes Before Your Scheduled Appointment Time

Pinehurst Medical Clinic Sleep Medicine Questionnaire

Name:_____ Date: _____

Referring Doctor: _____

Why are you seeing a sleep specialist:_____

_____

Please help us find out about you by filling out the "Patient" side of this form

PATIENT

When did your sleep issues begin? _____

Any trouble sleeping as a child or teenager? ☐ Yes ☐ No

If you have tried any sleep medications which ones?

_____ _____ _____

_____ _____ _____

Are you currently using a sleep aid and which one? _____

Tell us about your sleep schedule:

What is your weekday bedtime? _____ wake up? _____

weekend bedtime? _____ wake up? _____

How long does it take for you to fall asleep?_____minutes_____hrs.

What time do you eat dinner? _____

What snacks/drinks do you typically consume after dinner?

_____

What do you do after dinner? _____

_____

Do you do any of the following activities **in bed** before bedtime?

Circle all that apply: Read Watch TV Play Video Games

Talk on the Phone Use Cell Phone, Tablet, or Computer

How many times do you wake up in the middle of the night? _____

able to fall back to sleep easily? ☐Yes ☐ No ☐ Not always

How often do you need to get up to urinate during sleep? _____

What do you do when you are unable to sleep? _____

_____

.....

Do you work outside the home? ☐ Yes ☐ No

If yes, what are your hours? _____

Do you work weekends? ☐ Yes ☐ No Shift Work? 1st 2nd 3rd

Retired? ☐ Yes ☐ No

Disabled? ☐ Yes ☐ No

CLINICIAN

BMI>35

Age>50

Neck:

Gender:

Mallampati:

PATIENT	CLINICIAN

Do you take daytime naps? ☐ Yes ☐ No
How many per week? _____
How long do they last? _____
What time of the day? _____
Are the naps refreshing? ☐ Yes ☐ No
Do you doze (unintentional falling asleep) in the afternoon or evening?
☐ Yes ☐ No

.....

Do you ever experience restlessness in your legs before bedtime?
☐ No ☐ Yes: how many days per week? _____
If yes, does it disrupt your sleep? ☐ Yes ☐ No
Do you move or kick your legs while sleeping? *(Bed partner complains*)
☐ Yes ☐ No ☐ Don't know

.....

Currently smoking? ☐ Yes ☐ No
Do you drink alcohol beverages routinely at night? ☐ Yes ☐ No
If yes, how many? _____
Do you drink caffeinated beverages (coffee, tea, soda)? ☐ Yes ☐ No
How many before 6pm?_____How many after 6pm? _____
Do you drink any type of energy drinks? ☐ Yes ☐ No
If yes, how many and what times? _____
If you use any recreational drugs, please list: _____

.....

Have you ever felt the sudden loss of strength (arms/legs) in response to emotional experiences? ☐ Yes ☐ No
Have you ever felt paralyzed when you first wake up or when falling asleep? ☐ Yes ☐ No
Do you ever have vivid or menacing visions while you are falling asleep? ☐ Yes ☐ No
Do you walk in your sleep? ☐ Yes ☐ No
Talk in your sleep? ☐ Yes ☐ No
Do you have nightmares? ☐ Yes ☐ No
Do you ever accidentally urinate in bed? ☐ Yes ☐ No

.....

Are you sleepy or tired during the day? ☐ Yes ☐ No
How many days of the week? _____
When did it start_____weeks_____months_____years
Is it worsening? ☐ Yes ☐ No
Have you had close calls or accidents when driving due to sleepiness?
☐ Yes ☐ No
Have you had any issues with concentration or memory loss?
☐ Yes ☐ No

PATIENT CLINICIAN

*Please rate your chances of **falling asleep** in the following situations using the scale below:*

0 – would never doze
1 – slight chance of dozing
2 – moderate chance of dozing
3 --- high chance of dozing

_____ Sitting and reading
_____ Watching television
_____ Sitting inactive in a public place
_____ While a passenger in a car without a break
_____ Laying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after lunch (without alcohol)
_____ In a car, while stopped in traffic for a few minutes

*Rate the severity of your daytime **fatigue**:*

0---1-----2----3- - 4- - 5----6- - 7- - 8---9- - 10

None Moderate Severe

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No
If yes, are you on CPAP therapy? ☐ Yes ☐ No
If no, please answer the following:

Do you snore? ☐ Yes ☐ No
If yes, is it loud? ☐ Yes ☐ No
Is it getting worse? ☐ Yes ☐ No
Do you snore on your back? ☐ Yes ☐ No In a chair? ☐ Yes ☐ NoDo you gasp or choke during sleep? ☐ Yes ☐ No
Has anyone ever noticed you stop breathing during sleep? ☐ Yes ☐ No
Do you wake with a dry mouth? ☐ Yes ☐ No ☐ Sometimes
headache? ☐ Yes ☐ No ☐ Sometimes

Health Questionnaire:

Allergies:_____ ☐ None

Please list any current or past illnesses/medical conditions you have been treated for:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list all current medications: *If PMC patient, this is not needed.*

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Pinehurst Medical Clinic

Pinehurst Medical Clinic Consent for Release of Protected Health Information to Family

I consent to disclosure of the following protected health information about me to the following family member(s) or person(s) involved in my care or payment of my care:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

3. _____ Phone: _____ Relationship: _____

Check all that apply:

- ☐ All of my medical information
- ☐ Information necessary to schedule appointments for me
- ☐ Lab or test results
- ☐ Information necessary to provide, call in or pick up prescriptions for me
- ☐ Information necessary to help my family member(s) to pick up or arrange for medical equipment to be provided to me
- ☐ Information necessary to bill for or submit claims for care provided to me to government or private insurance payers

My consent will remain in effect as long as I am a patient at Pinehurst Medical Clinic, unless and until I notify Pinehurst Medical Clinic in writing of any changes.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Relationship to patient: _____

Pinehurst Medical Clinic

Account #_____

Patient Acknowledgment and Authorization

Please initial each section and sign to indicate acknowledgment and authorization.

_____ **Patient Payment Policy**
I have read and understand the Pinehurst Medical Clinic, Inc. Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Notice of Privacy Practices**
I understand that Pinehurst Medical Clinic, Inc. will use and disclose my/the patient's health information for the purposes of treatment, payment, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Assignment of Insurance Benefits**
I authorize the payment of medical benefits to Pinehurst Medical Clinic, Inc., and hereby assign to Pinehurst Medical Clinic, Inc. and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid, or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Consent to Treat**
I, the Patient/the Patient's Legal Representative, hereby grant permission to Pinehurst Medical Clinic, Inc., and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment.

_____ **Patient Rights and Responsibilities**
I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that the Pinehurst Medical Clinic health care providers will treat me with respect,
and I agree to do the same for them.

Patient Name (printed): _____

Patient/Legal Guardian Signature: _____ Date: _____

Pinehurst Medical Clinic

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are $75 for a new patient office visit, $25 for an established patient office visit, and $25-$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information: https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/
14. Failure to pay a balance due promptly may result in one or more of the following:
    a. Your account may be referred to a collection agency,
    b. Your past due status may be reported to the applicable credit bureaus,
    c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327.3159.

Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!

- View test & lab results
- Receive email care reminders
- Send & receive secure online messages
- Request appointments
- Request Rx refills
- Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.

Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com