PATIENT PACKAGE

Apnix
Sleep Diagnostics
The Houston Sleep Center

Katy

21703 Kingsland Blvd.
Suite 101
Katy, TX 77450
Phone (713) 349-9767
www.apnix.com

Apnix Sleep Diagnostics
The Houston Sleep Center

Patient Instructions

Preparation Before Testing:

1. Wash your hair the night before or the morning of your sleep study.
2. Avoid using hair products the day of the study. If this is not practical, please wash your hair when you arrive.
3. Arrive without make-up, if possible. If this is not practical, please wash your face to remove makeup when you arrive.
4. Acrylic nails and/or nail polish should not be worn to your study.
5. Unless you have a beard, please be clean-shaven. If you have a beard, we can work around it, but beard stubble is very difficult to work with.
6. Hairpieces and wigs must be removed. We must be able to get to your scalp to do the test.

On The Date Of Testing...

Please DO:

- Bring all your medications, insurance card(s), and ID or TXDL.
- Bring your own sleepwear (No silk clothing) and your own pillow if you wish. Plan for comfort.
- Bring any medications that you will need to take between the hours of 7:30pm & 7:30am and continue to take all your medications according to your doctor's instructions.
- Eat dinner before reporting for appointment.

Please DO NOT:

- Take any naps
- Drink caffeinated beverages after Noon
- Sleep past 9:00 am on the day of your test
- Drink any alcoholic beverages

The above instructions are in place to prevent any interference with test results.

Accommodations: Private sleep rooms, some come with full bathrooms and televisions for your convenience.

Going Home: You will be awakened at 6:00 am the next morning. You may leave as soon as you are ready to go. Checkout time is at 7:00 am at the latest.

Guests: Adult family members are welcome and encouraged to be present for the educational portion of the study. We discourage anyone from staying over-night. However, if you require the help of a personal care assistant due to a disability, we will be happy to have your PCA stay with you. If you feel it is necessary to have someone stay with you, please call Apnix Sleep Diagnostics at (713)349- 9767.

Important Questions: Call our office at (713)349-9767 from 8:30 am until 5:00 pm Monday through Friday. After hours or on the night of your study, you may call the main lab directly at (713)790-1991. You may leave a message on voicemail if outside of normal business

If You Need To Reschedule Or Cancel Your Study:

It is important that you arrive on time. If you know you will be late, please call Apnix Sleep Diagnostics at **(713)349-9767** to let us know. After hours or on the night of your study, you may call the main lab directly at (713)790-1991. You may leave a message on voicemail if outside of normal business hours. **If you do not show up for your scheduled appointment or cancel within 48 hours of your scheduled appointment, you will be charged a $150.00 no-show fee.**

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Directions/Contact Information

Katy Sleep Laboratory

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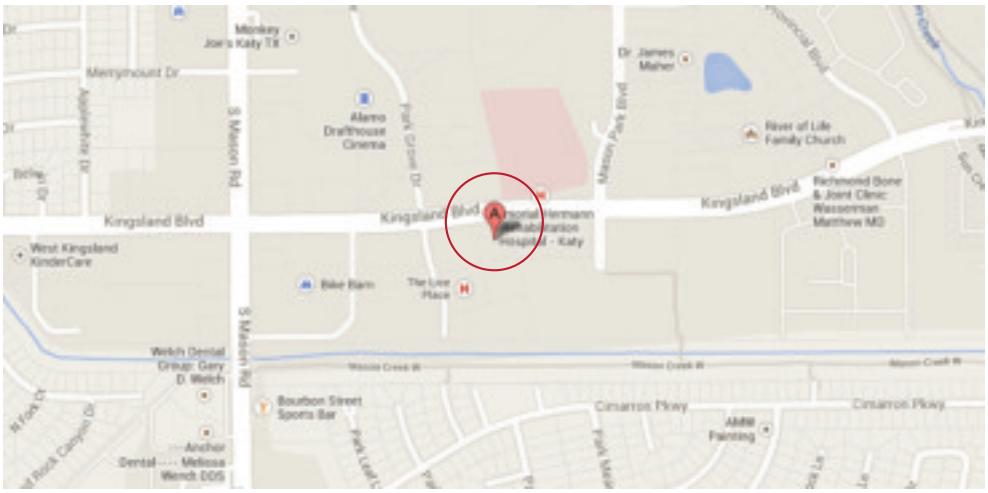

Directions to Apnix Katy Sleep Laboratory

Traveling I-10 West:

1. Take Mason Road Exit
2. Turn Left on Mason Road
3. Turn Left on Kingsland Boulevard
4. Sleep Lab in the Mason Park Professional Center
5. Please ring the doorbell when you arrive

Directions to Apnix Katy Sleep Laboratory

Traveling I-10 East:

1. Take Mason Road Exit
2. Turn Right on Mason Road
3. Turn Left on Kingsland Boulevard
4. Sleep Lab in the Mason Park Professional Center
5. Please ring the doorbell when you arrive

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Sleep Study Interpretation Fees

Dear _____,

We thank you for allowing Apnix to provide your sleep testing as requested by your physician. In addition to the technical portion of your study *(the test itself)*, there will be an additional charge for the physician who interprets the results of your sleep study. This is a separate charge and the amount is determined by your health insurance carrier based on your policy coverage.

Any questions regarding the interpretation and associated charges should be directed to the associated interpreting physician. This physician's name will be seen on statement billing and your insurance explanation of benefits.

Apnix does provide billing services for some interpreting physicians; therefore, you may see Apnix listed for both the technical and interpreting charges. Again, these fees are determined by your health insurance carrier and your portion is calculated based on your policy coverage.

We look forward to seeing you on your scheduled night, and to begin the process which will lead to the successful correction of your sleep disorder. If you have any questions, please contact the Apnix Billing Department at **(713) 349-9767** or email us at **billing@apnix.com**.

Sincerely,

Apnix Customer Service & Billing Departments

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Diagnostics Financial Policy

We thank you for choosing Apnix Sleep Diagnostics, a subsidiary of Oak Bend Medical, as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

A member of our customer service team has diligently verified your benefits with your insurance carrier in order to give you an estimate of the cost associated with the services Apnix Sleep Diagnostics will provide. We go to great lengths and are knowledgeable in this area, unfortunately, all insurance carriers claim that the "quotation of benefits is not a guarantee of payment" and so, the patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his or her treatment.

We are pleased to assist you by billing for our contracted insurers, however, be advised that it remains the patient responsibility to let Apnix know before the time of service if the insurance policy has changed, terminated or has been discontinued for any reason. If insurance policy has been terminated at time of service for any reason, patient will be financially responsible for 100% of the charges. It is your responsibility as the patient to provide us with the most correct and updated information about your insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

Patients are responsible for the payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and all major credit cards at our office and lab locations. Patients may incur, and are responsible for the payment of additional charges at the discretion of Apnix Sleep Diagnostics. These charges may include (but are not limited to): Charge for returned checks, charge for missed appointments without 48 hours advance notice (48 hours from 5:00 PM on the scheduled date of the appointment) and any costs associated with collection of patient balances.

I have read the above policy regarding my financial responsibility to Apnix Sleep Diagnostics, a subsidiary of Oak Bend Medical, for providing diagnostic services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Apnix Sleep Diagnostics or its affiliate Oak Bend Medical, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Please be advised that it remains patient responsibility to let us know at time of service if the insurance policy has changed or has been termed for any reason. If insurance policy has been termed at time of service for any reason, patient will be financially responsible for 100% of the charges.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

(If guarantor is not the patient)

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REVISED:4/15

Apnix Sleep Diagnostics

The Houston Sleep Center

Registration Form

(Please Print)

Whom may we thank for referring you today? ☐ Dr. ☐ Family/Friend ☐ Insurance plan ☐ Close to home/work ☐ Other:

PATIENT INFORMATION

Please provide driver's license or ID for copying.

PATIENT'S NAME						
First:	Middle:	Last:	☐ JR ☐ SR	☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr.	Marital status: ☐ Married ☐ Single ☐ Other ☐ Minor	Primary Language: ☐ English ☐ Spanish ☐ Other:

Birth Date: / /	Sex: ☐ M ☐ F	SSN (optional): - -	Spouse or Legal Guardian name:	Phone: ( ) -

Best number to contact: ☐ Home ☐ Cell ☐ Work	Home phone: ( ) -	Cell phone: ( ) -	Work phone: ☐ Unemployed ( ) - ext.	Email Address:

Physical Address:	City:	State:	Zip:
Mailing Address (if different):	City:	State:	Zip:

Emergency contact name:	Relationship to patient:	Phone 1: ☐ Home ☐ Work ☐ Cell ( ) -	Phone 2: ☐ Home ☐ Work ☐ Cell ( ) -

Name(s) of other individuals or organizations involved in patient care:

RESPONSIBLE PARTY(GUARANTOR)

Please provide driver's license or ID for copying.

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	GUARANTOR'S NAME First:	Middle:	Last:	Guarantor's Birth Date: / /	Is this person a patient of Apnix? ☐ Yes ☐ No

Best number to contact: ☐ Home ☐ Work ☐ Cell	Home phone: ( ) -	Cell phone: ( ) -	Work phone: ( ) - ext.	Employer name:

Mailing Address (if different):	City:	State:	Zip:

INSURANCE INFORMATION

Please provide insurance card(s) for copying.

#1 PRIMARY INSURANCE

Insurance card not available ☐

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	SUBSCRIBER'S NAME (Name listed on policy/card) First:	Middle:	Last:	Subscriber's Birth Date: / /	Is this person a patient of Apnix? ☐ Yes ☐ No

Insurance Company:	Policy/ID #:	Group #:	Employer name:

Insurance Co. Phone: ( ) -	Claims Mailing Address:	City:	State:	Zip:

#2 SECONDARY INSURANCE

Insurance card not available ☐

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	SUBSCRIBER'S NAME (Name listed on policy/card) First:	Middle:	Last:	Subscriber's Birth Date: / /	Is this person a patient of Apnix? ☐ Yes ☐ No

Insurance Company:	Policy/ID #:	Group #:	Employer name:

Insurance Co. Phone: ( ) -	Claims Mailing Address:	City:	State:	Zip:

#3 TERTIARY INSURANCE

Insurance card not available ☐

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other	SUBSCRIBER'S NAME (Name listed on policy/card) First:	Middle:	Last:	Subscriber's Birth Date: / /	Is this person a patient of Apnix? ☐ Yes ☐ No

Insurance Company:	Policy/ID #:	Group #:	Employer name:

Insurance Co. Phone: ( ) -	Claims Mailing Address:	City:	State:	Zip:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the supplier/provider. I understand that I am financially responsible for any balance. I also authorize the supplier/provider or insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature

_____

Printed Name

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General Conditions Of Treatment

THIS AGREEMENT, effective _____/_____/_____ and made this day by and between _____ ("patient") and Apnix Sleep Diagnostics LLC ("provider"), WITNESSETH:

FINANCIAL AGREEMENT: The undersigned agrees, where s/he signs as agent or as patient, that in consideration of the services to be rendered to the patient, s/he hereby individually obliges her/himself to pay the account of the provider in accordance with the regular rates and terms of the provider. Should the account be referred to an agency for collection, the undersigned shall pay reasonable collection fees and expenses. All delinquent accounts are subject to bear interest at the legal rate.

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION: In consideration of services rendered, I hereby transfer and assign to the provider and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance. I further assign all right to payment due me for medical and/or surgical services under said policies to provider, my attending physician, consulting physician, anesthesiologists, radiologists, ER physicians, professional laboratory and pathological services. I understand I am financially responsible for the above physician's services. I authorize the provider and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, Health or Hospital Plan.

MEDICARE PAYMENTS: (Patient's Certification, Authorization to Release Information and Payment Request) I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this of a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES AUTHORIZATION: I have been informed and understand that the provider will not assume responsibility for any personal property I may bring and/or keep in the facility during my stay.

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL PROCEDURES AND TREATMENT: I hereby authorize the attending physician and whomever he may designate as an assistant to administer such medications and treatment as is necessary, and such operations or procedures as are considered therapeutically necessary on the basis of findings in my case. I also consent to the administration of such anesthetics as are necessary. I have the right to appropriate assessment and management of pain. The provider supports my right to the highest level of pain relief that can be realistically and safely provided.

ACCIDENTAL EXPOSURE TO HEALTHCARE WORKER: I UNDERSTAND AND ACKNOWLEDGE THAT Texas Law provides that if any healthcare worker is exposed to my blood or other bodily fluid, the provider may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the provider and that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

NOTICY OF PRIVACY/PATIENT RIGHTS & RESPONSIBILITIES/ADVANCED DIRECTIVES: I have been given written material about HIPAA Notice of Privacy Practices. I also acknowledge receipt of a written statement regarding my rights and responsibilities as patient, which tells me how to register any complaint I might have. I have been given written materials about my right to accept or refuse medical treatments and I have been informed ob my rights to formulate Advanced Medical Directives.

AUTHORIZATION FOR VIDEO MONITORING AND PHOTOGRAPH: I hereby authorize the provider to monitor my treatment as is necessary via video camera and video monitor and to record the session on videotape for the purpose of diagnostic observation of the treatment that has been ordered by my physician. In addition, I authorize the provider to take still photographs of the patient for the purpose of display on the clinical documentation or results as is necessary.

THE UNDERSIGNED CERTIFIED THAT S/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

_____
Signature of Patient or Patient's Agent or Representative

_____ /
Relationship to Patient *Date*

_____
Witness

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Sleeping and Waking Behavior

Last Name: _____ First: _____ MI: _____ Date: _____

☐ Male ☐ Female Date of birth: ___/___/___ Age: _____ Marital Status: _____

Height: _____ Weight: _____ Neck or Collar Size: _____

Occupation: _____

Referring Physician: _____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section 1 Main SLEEP Complaint:

1. What is your sleep complaint? _____
2. How long has this been a problem? _____
3. Were there any events (weight gain, stress, illness etc) associated with the onset of your complaints? ☐ Yes ☐ No

Explain: _____

4. Have you had a sleep study or home screen? ☐ Yes ☐ No

   How long ago? _____

   What Type? _____

   Where? _____

5. Have you ever been on CPAP/BiPAP? ☐ Yes ☐ No

   When? _____

   Do you still use it? ☐ Yes ☐ No

6. What is the pressure setting? _____ cm H2O
7. Do you work shifts? ☐ Yes ☐ No

   Are they fixed or rotating? ☐ Fixed ☐ Rotating

   What are your work hours? _____

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Sleeping and Waking Behavior

Section 2 History of Sleep/Wake Disorder

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Use this 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

Do you fall asleep or become sleepy when:	0=Never 1=Occasionally 2=Often 3=Always
Driving?	☐0 ☐1 ☐2 ☐3
At work or school?	☐0 ☐1 ☐2 ☐3
Do you take intentional naps?	☐0 ☐1 ☐2 ☐3
Do you experience unintentional sleep episodes during the day?	☐0 ☐1 ☐2 ☐3
Do you experience any episodes of muscle weakness or loss of muscle control (especially with laughter or excitement)?	☐0 ☐1 ☐2 ☐3
Do you experience vivid dreamlike episodes when falling asleep?	☐0 ☐1 ☐2 ☐3
Do you feel unable to move (paralyzed) when falling asleep?	☐0 ☐1 ☐2 ☐3
How would you rate your overall daytime sleepiness?	☐None ☐Mild ☐Moderate ☐Severe

While asleep do you or have you been told, that you:	0=Never 1=Occasionally 2=Often 3=Always
Snore? ☐None ☐Mild ☐Moderate ☐Severe	☐0 ☐1 ☐2 ☐3
Hold your breath?	☐0 ☐1 ☐2 ☐3
Awaken choking or gasping for breath?	☐0 ☐1 ☐2 ☐3
Toss and/or turn excessively or have restless sleep?	☐0 ☐1 ☐2 ☐3
Experience palpitations, heart or chest pains at night?	☐0 ☐1 ☐2 ☐3
Awaken with heartburn or acid reflux?	☐0 ☐1 ☐2 ☐3
Walk or talk in your sleep? ☐Walk ☐Talk	☐0 ☐1 ☐2 ☐3
Have nightmares?	☐0 ☐1 ☐2 ☐3
Grind your teeth (bruxism)?	☐0 ☐1 ☐2 ☐3
Experience leg or arm jerks?	☐0 ☐1 ☐2 ☐3
Move about or engage in aggressive behaviors while asleep (e.g. thrashing, kicking, punching, yelling or hitting?)	☐0 ☐1 ☐2 ☐3
Wake up with a dry mouth?	☐0 ☐1 ☐2 ☐3
Wake up with headaches?	☐0 ☐1 ☐2 ☐3

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Sleeping and Waking Behavior

Epworth Sleepiness Scale (ESS)

Indicate One: ☐ Pre-CPAP ☐ Post-CPAP

0 = would never doze **1 =** slight chance of dozing **2 =** moderate chance of dozing **3 =** high chance of dozing

Situation:	Chance of Dozing
Sitting and Reading	☐ *0* ☐ *1* ☐ *2* ☐ *3*
Watching Television	☐ *0* ☐ *1* ☐ *2* ☐ *3*
Sitting inactive in a public place for example a theatre or a meeting	☐ *0* ☐ *1* ☐ *2* ☐ *3*
As a passenger in a car for an hour without a break	☐ *0* ☐ *1* ☐ *2* ☐ *3*
Lying down to rest in the afternoon	☐ *0* ☐ *1* ☐ *2* ☐ *3*
Sitting and talking to someone	☐ *0* ☐ *1* ☐ *2* ☐ *3*
Sitting quietly after lunch (when you've had no alcohol)	☐ *0* ☐ *1* ☐ *2* ☐ *3*
In a car, while stopped in traffic	☐ *0* ☐ *1* ☐ *2* ☐ *3*

Total Epworth Sleepiness Score (ESS): 0

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Sleeping and Waking Behavior

Section 3 Sleep Habits

1. What time do you go to bed?
   Weekdays:_____ Weekends:_____
2. What time do you usually wake up?
   Weekdays:_____ Weekends:_____
3. How long does it take you to fall asleep?
   a.) How many times do you awaken at night?_____
   b.) How long do you remain awake?_____
   c.) What reason? ☐Bathroom ☐Noises ☐Pets ☐Other: _____
4. Do you feel refreshed in the morning upon awakening? ☐Yes ☐No
   Describe how you feel:
   - ☐ Very sleepy
   - ☐ Sleepy, but wake up soon
   - ☐ Wide awake, ready to go
5. Do you take naps during the day? ☐Yes ☐No
   a.) If yes, when?_____ How many?_____ How long?_____
   b.) Are the naps refreshing? ☐Yes ☐No
6. Do you have trouble falling asleep at night? ☐Yes ☐No
7. Do you feel that you have to try hard to fall asleep? ☐Yes ☐No
8. Do you have trouble falling back asleep after you awaken? ☐Yes ☐No
9. Do you dread getting into bed for fear of "never falling asleep"? ☐Yes ☐No
10. Do you consume alcoholic beverages to aid with sleep on-set? ☐Yes ☐No
11. Do you take any medication(s) (Prescription and/or OTC sleeping aids) to help you sleep? ☐Yes ☐No
    If Yes, please list:
    *Prescription and/or OTC sleeping aids*_____ *How many times per week:*_____
    *Prescription and/or OTC sleeping aids*_____ *How many times per week:*_____
    *Prescription and/or OTC sleeping aids*_____ *How many times per week:*_____
12. Do you experience crawling/aching feelings in your legs that make you want to move/walk? ☐Yes ☐No
13. Are you unable to sit or stay still when relaxing or sitting for extended periods? ☐Yes ☐No
14. Do your legs jerk before or during sleep? ☐Yes ☐No

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Sleeping and Waking Behavior

Section 4 Medical/Surgical/Psychiatric History

- ☐ High Blood Pressure
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Coronary Artery Disease
- ☐ Back/Neck Pain-chronic
- ☐ ADD or ADHD
- ☐ Bipolar Disorder
- ☐ Substance Abuse
- ☐ Lung Disease (such as COPD)
- ☐ Elevated Cholesterol
- ☐ Stroke
- ☐ GI Disease (ulcers, colitis, etc.)
- ☐ Cancer (of what?)
- ☐ Frequent nighttime urination
- ☐ Heart Valve Problems
- ☐ Gastric Reflux
- ☐ Depression
- ☐ Nocturia
- ☐ Liver Disease/Hepatitis
- ☐ Seizures or Epilepsy
- ☐ Migraine or Frequent Headaches
- ☐ Parkinson's
- ☐ Dementia (Alzheimer's, etc.)
- ☐ Fibromyalgia
- ☐ Congestive Heart Failure
- ☐ Neuropathy (nerve problems)
- ☐ Anxiety
- ☐ Teeth Grinding

List ALL prescription and over-the-counter medications/drugs you are taking or recently have taken (with the past 6 months):

Name	Dosage	How Often	Reason

Past Medical or Surgical history (Include all hospitalizations within the past five years):

Problem	Date of Onset	Treatment	Resolve/Current

Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____

Do you smoke? ☐ Yes ☐ No If yes, how long? _____ How much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how long? _____ How much? _____

Do you drink caffeinated beverages *(coffee, tea, cola)*? ☐ Yes ☐ No How much? _____

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Sleeping and Waking Behavior

Section 5 General History

1. Have you had any problems with your memory or concentration?
   ☐Yes ☐No *If yes, explain:* _____

2. Have you noticed any changes in your mood or have you experienced any increase in irritability lately?
   ☐Yes ☐No *If yes, explain:* _____

3. Are you having any other problems e.g., stress, anxiety, or pressures?
   ☐Yes ☐No *If yes, explain:* _____

4. Have you been depressed and or anxious lately?
   ☐Yes ☐No *If yes, explain:* _____

5. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc?)
   ☐Yes ☐No *If yes, explain:* _____

6. Do you often travel across time zones that affect your sleep/wake schedule?
   ☐Yes ☐No *If yes, explain:* _____

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Split-Night Sleep Studies

Your physician may have ordered a split-night sleep study for you. The purpose of this split-night study is to accomplish both diagnostic and treatment phases of testing in one session, preventing the need for a second study.

At Apnix, when a split-night study is ordered, we make every effort to accomplish this. Unfortunately, this is not always possible. In order to complete the diagnostic phase of testing and move to the treatment phase, several things have to happen, they are as follows:

1. Set amount of time must occur. For most insurance plans this is a minimum of two hours. Some However, require more time for the diagnostic phase.

2. A set number of apneas, hypopneas and arousals must occur. These are various types of disruptions to your breathing. A minimum number must be met to be considered a valid diagnostic study.

3. Most of these disruptions occur during our REM (dream stage) sleep. These periods occur approximately every 45 to 90 minutes. If the onset, or duration of these REM periods are not sufficient, often a diagnostic decision cannot be made and the treatment phase cannot be initiated.

4. We have to be very cautious. If the sleep technician terminates the diagnostic portion of the study prematurely without enough of the above noted events, then the test is not valid and your insurance will not pay for further testing or treatment. For this reason our technicians are required to be certain of a positive outcome before beginning treatment.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

Apnix is accredited by the American Academy of Sleep Medicine, and we have specialized in the diagnostics and treatment of sleep disorders for 20 years. We take our responsibility to you and your doctor very seriously, and we promise you that you will be tested and treated in an ethical, honest and clinically sound manner. If you have any questions about how our decisions were made in your case, feel free to contact us to discuss your study.

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REV:1/14

Apnix Sleep Diagnostics
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Discharge Instructions

Dear Patient:

BEFORE YOU LEAVE, PLEASE CHECK THE BEDROOM AND MAKE SURE THAT YOU HAVE ALL OF YOUR BELONGINGS. APNIX IS NOT RESPONSIBLE FOR ANY ITEMS LEFT AT THE SLEEP LABORATORY.

The following instructions are intended to help you understand the process of evaluating your sleep study and the subsequent steps that will be taken.

1. It will take approximately ten (10) days for your sleep study to be analyzed and interpreted by our physician.
2. The results of your study will then be sent to your referring physician who initially ordered the sleep study. If your sleep study reveals that you have a sleep disorder, your physician may order a second sleep study for treatment options or further evaluation.
3. After you have completed a CPAP/BiPAP titration study, Apnix will contact you once we receive the order from your physician to set up your machine, either here at our office or your home at your convenience.
4. If you have not heard from your physician within the next two weeks, please call your physician's office to check on the status of your study or to arrange a follow-up appointment.
5. If one of your symptoms is daytime sleepiness, please do not drive or operate heavy equipment when you are sleepy. Sleepy drivers are at an increased risk of being involved in motor vehicle accidents. Please Drive Carefully!

✓ ***Please keep a copy of these instructions for future reference***

Do you have any friends or relatives whom you think may have a sleep disorder?
Refer them to Apnix Sleep Diagnostics for an evaluation today.

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REV:1/14