



Baytown Sleep Lab

2802 Garth Rd
Suite 205
Baytown, Texas 77521

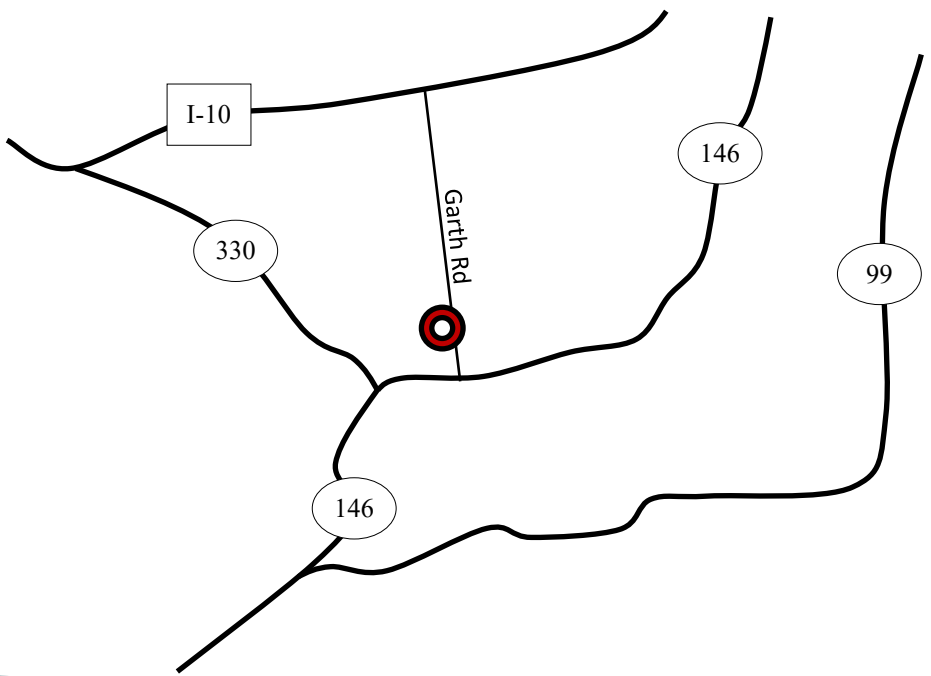


This lab is located inside a medical office building: *Baytown Primary Medical Tower*
When you arrive at the lab, park on the **RIGHT** side of the building.
Enter the building via the side door entrance (**RIGHT** side of building).

ALL DOORS WILL BE LOCKED

Push the button on the pad and someone will buzz you in.

Scan QR Code for Lab Map



Cancellation fees may apply to any appointment cancelled within 2 business days or for late arrivals.

APPOINTMENT TIME IS 8:00 PM

Preparing for your sleep study

For the most part, to get the best results out of your sleep study, technicians want you to go about your usual evening routine as much as possible. However, there are certain things you can do to make the study go more smoothly, and still garner the most accurate results.

What to do before arriving for the study

- Have all paper work given filled out ahead of time.
- Let the clinic know well in advance of your appointment if you have any special needs (i.e. trouble getting in/out of bed, any physical limitations, frequent nighttime urination, impairments, etc.).
- Wash and dry your hair before going to the clinic. Do not apply sprays, conditioners, gels, or oils to your hair. There are a number of electrodes that will be administered and these substances can make adhering equipment difficult.
- Try and avoid eating or drinking anything with caffeine a few hours before your study. If possible, avoid caffeine after your lunch.

What to bring

- Bring your **health insurance card** and a **valid form of identification** (Driver's License or State ID Card). Bring and take all of your regular prescribed medications according to your physician's instructions.
- Bring **two-piece sleeping clothes** such as pajamas or shorts and a shirt, no silk. Although your comfort is very important, we request modest attire for the comfort of others.
- Bring a favorite pillow or blanket if desired.
- Bring any other specialty items you may need for sleep or will need first thing in the morning such as toiletries, toothpaste, toothbrush, etc.
- Bring clothes to go home in, or clothes for work if heading to your job in the morning.

DO

- DO arrive on time for your appointment. If you are late your study might need to be rescheduled.
- DO have your evening meal prior to showing up for your study.
- DO bring all your medications, insurance cards and id.
- DO take your medications according to your doctor's instructions.
- DO bring any medications you need the night of or the morning after your study (7:30pm-7:30am).
- DO bring 2-piece modest sleepwear (no silk clothing).
- DO bring your own pillow if you wish. Plan for comfort.

DO NOT

- DO NOT arrive early for your appointment. *Labs are not staffed during non-study hours.*
- DO NOT nap during the day so that going to sleep will be easier during your study.
- DO NOT drink/take caffeine or stimulants for 12 hours before your scheduled appointment, unless prescribed by your doctor.

Accommodations

Private rooms, most with full bathrooms, cable tv, wi-fi internet

Guests

We discourage anyone from staying over-night. However, if you require the help of a personal care assistant (PCA) 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 corporate office during normal business hours, 8:30am to 5:00pm Monday through Friday, by phone (713) 349-9767.

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.

It will take approximately ten business (10) days for your sleep study to be analyzed and interpreted by a physician.

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. Apnix may contact you to schedule a follow up titration study.

After you have completed a titration study, Apnix may contact you once we receive the order from your physician to set up your machine.

If you have not heard from your physician within the next few weeks, please call your physician's office to check on the status of your study or to arrange a follow-up appointment.

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!

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.

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.

We make every effort to complete a split-night study; 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 succinct, 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. Sleep Diagnostics The Houston Sleep Center.
5. If the treatment phase could not be initiated and only the diagnostic portion of the study was performed, your physician may order a second sleep study for treatment options or further evaluation.



The Houston Sleep Center

Diagnositics Financial Policy

Patient Name: _____

Definitions:

Deductible: An annual amount you must pay before your insurance begins to pay.

Coinsurance: A fixed percentage of the allowable amount that the patient is responsible for paying on covered expenses. This amount is usually *applied* to the out-of-pocket expense maximum.

Copay: A fixed amount that the patient pays each time they receive covered services. This amount usually *does not apply* to the out-of-pocket expense maximum.

Out-of-pocket Expense Maximum: A fixed amount that the patient is responsible for paying on covered expenses. This amount is usually a sum of network coinsurance payments.

Please be advised that any amount we may or may not collect from you at the time of services is based on information obtained from your insurance company(ies) at the time of verification of benefits. The final determination of patient responsibility is made by your insurance company when the claim is processed and your portion due will be shown on the Explanation of Benefits (EOB) issued by your insurance company. Please notify us immediately, with a minimum of 48 hours prior to your appointment, if you have any changes in your insurance. Presenting new insurance at the time of your study may result in your responsibility for the full billed charge.

Cancellation and No Show Fees

If you need to cancel your appointment, please call Apnix as soon as possible. You must speak with a staff member on the phone. **DO NOT LEAVE A MESSAGE. Call (713) 349-9767 during business hours. A no show fee of \$250.00** may apply if you do not call ahead to cancel at least 2 business days (or 36 hours) prior to your study. For your study we have assigned a highly-trained technologist to be present for a total of 12 hours. It is very costly to our organization if we have to send this person home. A number of patients are waiting to get in for testing, your unused appointment could have been given to someone else. If you are not at the Sleep Center by 45 minutes after your scheduled time and have not notified us, you will be marked as a no-show and charged the **no show fee of \$250.00**.

Sleep Study Interpretation Fees

In addition to the technical charge for the sleep test, there will be an additional charge for the professional portion (interpretation) of the test. This additional charge will also be billed to your insurance(s) on file. The patient will be responsible for any amount applied to deductible, copay, or coinsurance for the interpretation.

I have read and understand the financial policy of Apnix. I also understand that I am responsible for all amounts applied to my deductible, copay, or coinsurance.

Signature of Patient or Patient’s Agent or Representative

Date

Relationship to Patient

General Conditions of Treatment

THIS AGREEMENT, effective ____/____/____ and made this day by and between _____ (“patient”) and **APNIX** (“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 of 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 _____ Date _____

Relationship to Patient _____

Patient Sleep History Questionnaire

If this is someone other than the patient filling out this form, please indicate your name and relationship to the patient: _____

Patient Profile

Date Completed: _____

Male Female

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Neck or collar size: _____

Occupation: _____ Shift work Unemployed Student

Marital Status: Single Married Separated Divorced

Epworth Sleepiness Scale (ESS)

Indicate One: Pre-CPAP Post-CPAP

Chance of Dozing: 0 = would never doze, 1 = slight chance, 2 = moderate chance, 3 = high chance

Sitting and Reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching Television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting inactive in a public place (i.e. meeting or movie theatre)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
As a passenger in a car for an hour without a break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lying down to rest in the afternoon	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after lunch (when you've had no alcohol)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
In a car, while stopped in traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Total Epworth Sleepiness Score: _____

Patient Sleep History Questionnaire

How would you rate your overall daytime sleepiness? None Mild Moderate Severe

Have you had a sleep study or home apnea screening before? Yes No

How long ago? This year Last year 2-5 years ago 6-10 years ago 10+ years

Where was the study done? _____

Do you drink alcohol? How much? _____ per day week month None

Do you use tobacco products (smoke, snuff, etc.)? How much? _____ per day week month None

What time do you go to bed? Weekdays: _____ Weekends: _____

What time do you usually wake up? Weekdays: _____ Weekends: _____

Do you take naps during the day? No Naps Are the naps refreshing? Yes No

If YES: When? _____ How many? _____ How long? _____

Do you, or have you been told that you: **0 = Never, 1 = Occasionally, 2 = Often, 3 = Always**

Have trouble falling asleep at night? 0 1 2 3

Feel that you have to try hard to fall asleep? 0 1 2 3

Have trouble falling back asleep after you awaken? 0 1 2 3

Dread getting into bed for fear of "never falling asleep"? 0 1 2 3

Snore? None Mild Moderate Severe 0 1 2 3

Hold your breath while sleeping? 0 1 2 3

Wake up with headaches? 0 1 2 3

Feel refreshed in the morning upon awakening? 0 1 2 3

Experience crawling/aching feelings in your legs that make you want to move/walk? 0 1 2 3

Legs jerk before or during sleep? 0 1 2 3

Patient Name: _____

Patient Sleep History Questionnaire

Medical History

- | | | |
|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease (COPD) | <input type="checkbox"/> Liver Disease/Hepatitis |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines or Frequent Headaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GI Disease (ulcers, colitis, etc.) | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Teeth Grinding/BruXism | <input type="checkbox"/> Dementia/Alzheimer's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nocturia/Frequent nighttime urination | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Back/Neck Pain (chronic) | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Neuropathy (nerve problems) |
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Substance Abuse: _____ |

Are you allergic to any medications/drugs? Yes: _____

List ALL medications/drugs you are taking or recently have taken within the past 6 months: *List Attached*

Prescription Medicines	Dosage	How Often	Reason
------------------------	--------	-----------	--------

Over-the-Counter (OTC) Medicines	Dosage	How Often	Reason
----------------------------------	--------	-----------	--------

Past Medical or Surgical history (include all hospitalizations within the past five years): *List Attached*

Problem	Date of Onset	Resolved/Current	Treatment
---------	---------------	------------------	-----------

Patient Name: _____