West Virginia Sleep Centers, Inc.
24 Mallard Court
Beckley, WV 25801
304.253.5420

CONSENT FOR POLYSOMNOGRAPHY TEST

WITH VIDEOTAPING

I, ________________________, am fully aware of the procedures associated with polysomnographic testing. Upon signing this consent, I agree to the overnight procedure, and further agree to be videotaped throughout the entire testing process. I understand and acknowledge that this is for **my** protection, as well as for the protection of the sleep center. I also comprehend that this authorization serves as a legal and binding contract between me, and the West Virginia Sleep Centers, Inc.

____

Signature (Patient or Legal Guardian) Date

____

Witness

______________ ______________ ____________________

Height Weight Date of Birth

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THE EPWORTH SLEEPINESS SCALE: The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score This is your Epworth score	____

Patient's Name: ________________________________ **Date:** ____________

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CONSENT FOR RELEASE OF INFORMATION

I hereby authorize you to release the following confidential information described below, only for the parties also described below.

Description of specific information to be used to disclosed: Sleep Study Records

Other records to be released: ____

Covering dates and care as follows: From_____ To_____ or all dates of outpatient treatment provided_____.

Purpose or need for release of information: __________________________________

Information to be released to : ____

This authorization shall remain in effect from the date signed below until the following expiration date, or event: ____

I understand that:

-I may inspect or copy the protected health information to be used or disclosed.

-I may revoke this authorization at any time by contacting this office in writing.

-Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.

-I may refuse to sign this authorization, and treatment or payment for services will not be a condition to receive these services upon my refusal (except to the extent that the authorization is for research-related treatment, in which case research-related treatment may be refused).

Patient Name:______________________ **Signature:**________________________

SSN:_____-____-_____ **Witness:**_________________________

Relationship to Patient: _____________________________ **Date:**______________
(If signed by personal representative of the patient)

Revocation to Release: (must be received in writing or signature below from patient or patient representative)
Patient or Representative Signature:_____________________________**Date:**______________

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ________day of _____________ 20______.

Print Patient Name ____

Signature ____

Relationship to Patient ____

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POST-SLEEP QUESTIONNAIRE

1. How long do you think it took you to fall asleep?

2. How would you describe your quality of sleep?

3. Do you feel you slept the same, better, or worse than you do at home?

4. Was the length of your sleep shorter, longer, or the same as at home?

What time were you woke up?____________

5. Additional Comments:

Patient's Name:__________________________________ **Date:**___________________

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Patient Satisfaction Survey

Please rate each question on a scale from 1 to 5. **1 being the poor and 5 being excellent.** Feel free to add your comments for each question.

1. Do you feel the scheduling process for your sleep study was easy and convenient?
   poor 1 2 3 4 5 excellent

   Comments:____
   ____

2. Were the facilities at WVSC clean? poor 1 2 3 4 5 excellent

   Comments:____
   ____

3. Were the facilities at WVSC comfortable? poor 1 2 3 4 5 excellent

   Comments:____
   ____

4. Was the staff knowledgeable and courteous? poor 1 2 3 4 5 excellent

   Comments:____
   ____

5. Would you recommend us to friends and family? poor 1 2 3 4 5 excellent

   Comments:____
   ____

Patient name (optional) ______________________________ **Date**________________

Thank you for taking the time to tell us about your experience at West Virginia Sleep Center. Your Feedback is *extremely* important to us. Feel free to contact us for additional comments or problems at 304-253-5420.