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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DME Freedom of Choice

If there is a need for medical equipment after your test, please indicate which durable medical equipment company you would like to use.

I choose ____to provide any CPAP or Oxygen equipment I may need in the future. I understand I am free to choose any provider I want.

___________I do not have a preference. Please choose for me.

If you do not have a preference of durable medical equipment companies, then we will select one from our rotating list of companies. This list does not imply our endorsement of any particular provider.

I hereby authorize the release of my information to the medical equipment company as indicated above.

Signature____ Date______________________

Printed Name____

Witness____

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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.