COMPREHENSIVE SLEEP CARE CENTER

LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Diagnostic & Treatment Center for Sleep Disorders
P. 703-729-3420 F. 703-729-3422
www.comprehensivesleepcare.com

PEDIATRIC PATIENT INFORMATION

Childs Full Name: _____Prefix/Suffix: _____ Todays Date: _____/_____/_____

Sex of child: ❑ M / ❑ F Child's Date of Birth: _____/_____/_____ Child's Age: _____

Home Address: _____City: _____State: _____Zip: _____

Parents Cell Phone #: _____-_____-_____ Home Phone #: _____-_____-_____

Parent Email Address: _____ Parents Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Childs Language: ❑ English ❑ Spanish ❑ Indian (Hindi/Tamil) ❑ Russian ❑ Other _____

Childs Ethnicity: ❑ Caucasian ❑ American Indian ❑ Asian ❑ African American ❑ Hispanic ❑ Native Hawaiian or ❑ Pacific Islander ❑ Other _____

PREFERRED METHOD OF CONTACT □ Text Message □ Email □ Cell Phone □ Home Phone

PARENT EMPLOYER | PHARMACY INFORMATION

Parents Employer: _____ Employer Phone #: _____-_____-_____

Employer Address: _____ City: _____State: _____Zip: _____

Parents Job Status: ❑ FULL TIME ❑ PART TIME ❑ STUDENT ❑ RETIRED

Child's Job Status: ❑ FULL TIME ❑ PART TIME ❑ STUDENT

Child's Preferred Pharmacy: _____ Pharmacy Phone #: _____-_____-_____

Pharmacy Address: _____ City: _____State: _____Zip: _____

EMERGENCY CONTACT / GUARANTOR INFORMATION

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____Sex: ❑ M / ❑ F Date of Birth: _____/_____/_____

Home Address: _____

Cell Phone #: _____-_____-_____

Guarantor is the responsible/billed party (Parent or Guardian)

GUARANTOR CONTACT (please check at least one) ❑ Guarantor ❑ Policy Holder/Insured

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Patient: _____ Sex: ❑ M / ❑ F Date of Birth: _____/_____/_____

Home Address: _____

Cell Phone #: _____-_____-_____

REFERRAL INFORMATION: IMPORTANT PLEASE PROVIDE BOTH PHYSICANS

How did you hear about us?

❑ **REFERRING DOCTOR (Please list info below)** ❑ **PRIMARY CARE DOCTOR (Please list info below)**

❑ **Internet** ❑ **Advertisement** ❑ **Insurance** ❑ **Inspire Web Page** ❑ **ZocDoc** ❑ **Family/Friend** ❑ **Previous Patient**

❑ **Other:** _____

REFERRING DOCTOR INFO (Please list below)

Name: _____

Address: _____

City/State: _____

Phone: _____

PRIMARY CARE DOCTOR INFO (Please list below)

Name: _____

Address: _____

City/State: _____

Phone: _____

INSURANCE POLICY INFORMATION

Type (please check one only) ❑ Health ❑ Auto ❑ Workers Comp ❑ Other: _____

PRIMARY INSURANCE NAME: _____

Claims Address: _____ Phone #: _____-_____-_____

Policy #: _____ Group #: _____

Policy Holder Information (if different)

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Policy Holder Phone #: _____-_____-_____

SECONDARY INSURANCE NAME

Type (please check one only) ❑ Health ❑ Auto ❑ Workers Comp ❑ Other: _____

SECONDARY INSURANCE NAME: _____

Claims Address: _____ Phone #: _____-_____-_____

Policy #: _____ Group #: _____

Policy Holder Information (if different)

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Policy Holder Phone #: _____-_____-_____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to LMG, PC, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG, PC or any of its affiliates.

_____ _____/_____/_____

Patient / Guardian Signature **Date:**

Pediatric Patient Questionnaire

Childs Full Name:		Child DOB: _____/_____/_____	Today's Date: _____/_____/_____

1. What is your child's height? _____

2. What is your child's weight? _____

3. Please tell us the main reason for the child's office visit or test with us:

❑ Snoring ❑ Excessive daytime sleepiness ❑ Leg movements during sleep ❑ Difficulty falling/staying asleep

❑ Poor sleep-wake schedule ❑ Disruptive behaviors during sleep ❑ Other: _____

4. When did your child's sleep problem start? _____

5. Has your child been diagnosed hyperactive? ❑ YES ❑ NO

6. Do you know, or have you been told that your child snores? ❑ YES ❑ NO ❑ UNKNOWN

7. Has your child ever had an overnight sleep study (Polysomnogram)? ❑ YES ❑ NO ❑ UNKNOWN

If yes, when and what did the results show? _____

8. What is your child's bedtime? _____

9. Does your child have trouble falling or staying asleep? _____

10. How many times does your child usually awaken during the night? _____

11. How many hours of sleep does your child get at night? _____

12. Any history of tonsillectomy and adenoidectomy? _____

13. Any history of strep throat and ear infection? _____

14. SNORING & SLEEP APNEA

Does your child snore loudly, gasp or choke at night? ❑ YES ❑ NO ❑ UNKNOWN

Does your child often awaken with a dry mouth/sore throat/morning headaches ❑ YES ❑ NO ❑ UNKNOWN

Does your child sleep walk? ❑ YES ❑ NO ❑ UNKNOWN

Does your child have night terrors? ❑ YES ❑ NO ❑ UNKNOWN

15. EPWORTH SLEEPINESS QUESTIONNAIRE (please answer questions that are applicable)

In the table below, please indicate how easily your child dozes off to sleep in the following situations:

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 TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or classroom)	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 when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
Doing homework or taking a test	0	1	2	3

16. MOVEMENTS DURING SLEEP

Does your child ever experience twitching or jerking of their legs while asleep? ❑ YES ❑ NO ❑ UNKNOWN

Does child have uncomfortable sensations (e.g. insects crawling) in legs that makes it difficult to fall asleep?❑YES ❑NO ❑UNKNOWN

Does your child ever feel an urge to move or "reposition" legs while sitting or lying still? ❑ YES ❑ NO ❑ UNKNOWN

Does your child have any discomfort in legs at night? ❑ YES ❑ NO ❑ UNKNOWN

17. OTHER SLEEP SYMPTOMS

When falling asleep or waking up, has your child experienced seeing or hearing things that weren't there?❑ YES ❑ NO ❑ UNKNOWN

When falling asleep or waking up, has your child ever experienced very brief periods of being unable to move their arms or legs even though they tried? ❑ YES ❑ NO ❑ UNKNOWN

18. MEDICATION (OPTIONAL, IF YOU HAVE TIME)

Please list all prescription and over-the-counter medications that your child currently uses:

Name	Dosage	Frequency	Reason for Medication

ALLERGIES: Latex □ YES □ NO Other Allergies_____

Other Important Notes You Feel We Should Know? _____

_____

_____

_____

_____

_____ _____/_____/_____

Parent / Guardian Signature Date:

_____

Relationship to patient

CANCELLATION POLICY

Office Visit appointments not cancelled with a minimum of 2 business days' notice will be charged a $30.00 cancellation fee. This fee is NOT billable to your insurance carrier.
Sleep Study related appointments not cancelled with a minimum of 3 business days will be charged a $150.00 cancellation fee. This fee is NOT billable to your insurance carrier. For all Sleep Study related appointments, we have arranged in advance to have a Registered Polysomnogram Sleep Technician available to provide your Sleep Study.
If you must cancel or reschedule your appointment, we ask that you contact us directly at 703.729.3420, OPTION# 2 (Monday-Friday 8:30am-4:30pm). After hours please select OPTION #3.

FINANCIAL POLICY

This consent applies to Loudoun Medical Group, PC (herein after referred LMG) d/b/a Comprehensive Sleep Care Center, or any of its affiliates or agents, lenders, or any third-party servicer acting for LMG or any of its affiliates.
I hereby authorize my insurance benefits to be paid directly to the physician and/or physician group for which I am financially responsible for all charges. I also consent to the release and re-disclosure of my medical record to enable or facilitate the payment, collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan.
Our office will provide you a general breakdown of coverage on your first visit and this information will be disclosed to you via a "Call In Form" which you are required to sign. Please note, this information is used for obtaining preliminary insurance information only and this is not a guarantee of benefits; we highly recommend that you contact your insurance carrier to get more specific approval for all services.
If at any point you change insurance, or your insurance policy terminates or cancels coverage, you will be fully responsible for any and all charges that are not subject to being refiled with any new insurance provided. Most insurance(s) have timely filing requirements that if they are not met we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy. <u>If we are unable to refile your claims, you will be fully responsible for all charges.</u> This includes any SECONDARY insurance related information as well.

REFERRAL POLICY

I understand that if my insurance carrier requires a written "Insurance Referral" from my Primary Care Physician, I am responsible for obtaining the insurance referral prior to being seen in our office and prior to be testing.
We recommend that all patients call and confirm this directly with your health insurance or check with your PCP office ahead of time. If an "insurance referral" has not been obtained before my appointment, I will be asked to sign a "Waiver Form" acknowledging that if the referral is not able to be obtained timely I will be financially responsible for the charges incurred.

FAMILY WE CAN SHARE YOUR PROTECTED HEALTH INFORMATION WITH:

We understand the importance of being able to communicate or share certain pieces of health-related information to your **family members**. The HIPAA Privacy Act requires that we must obtain permission from you before we can share any health-related information which includes: Appointment dates, Insurance/Account billing, and treatment related information. If you would like for us to be able to share certain pieces of this information, please make sure you list their names below.

1. _____ (first and last name required) _____/_____/_____ (DOB-required)
Relationship ❑ spouse ❑ family member _____❑ guardian ❑ other _____

2. _____ (first and last name required) _____/_____/_____ (DOB-required)
Relationship ❑ spouse ❑ family member _____❑ guardian ❑ other _____

❑ I do not want my information shared with anyone in my family

CONSENT FOR VIDEO TAPINGS for IN-LAB SLEEP STUDY

As part of a diagnostic sleep study, video may be required. All information and data will be kept confidential.
I, _____, hereby authorize the use of video surveillance for the purpose of medical diagnosis. If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____ have been given the option to receive a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

Patient / Guardian Signature: _____Date: _____/_____/_____

Relationship to Patient _____

MEDICAL RECORDS RELEASE
FROM/TO ANOTHER MEDICAL FACILITY

Please complete the following information:

Patient's Name: _____

Address: _____

Date of Birth: _____

Phone: _____

Release my protected health information to the following physician/facility/entity and/or those directly associated in my medical care.

COMPREHENSIVE SLEEP CARE CENTER

FAX – 703-729-3422

Or to another medical group listed below

_____

_____

_____

_____ _____

Signature of Patient (or Patient's Personal Representative) **Date**

_____

Printed Name of Patient Representative

IMPORTANT SLEEP STUDY INSTRUCTIONS
FAILURE TO FOLLOW INSTRUCTIONS MAY RESULT IN STUDY CANCELATION

HOW TO PREPARE FOR YOUR IN-LAB SLEEP STUDY

- **On the day of the sleep study, make sure that your hair is clean, dry, and free of oils, gels, hair spray, and other products. Please remove any hair extensions or wigs. The scalp must be accessible, or we will be unable to do the study.**
- **You will have sensors with gel/paste, and possibly tape, placed on your head/hair, chin, around your eyes, legs, chest, and finger, to record sleep activity during your sleep study. The paste can be difficult to brush out of your hair and you may need to wash it again to completely remove paste.**
- Avoid napping on the day of the study.
- Eat your regular evening meal before you arrive for your sleep study.
- Avoid alcohol, sedatives, stimulants, and caffeinated beverages (coffee, tea, and cola) for 24 hours before the study.
- Wear comfortable clothing to sleep in and feel free to bring your favorite pillow or blanket.
- Bring your regularly scheduled medications and plan to take them as you normally would unless your physician instructs otherwise.
- Bring reading materials, laptop, or other activities to occupy your free time. (Wi-Fi is available.)
- If you are under 18 years of age, a parent or guardian is required to stay with you for the entire duration of testing. Most rooms have an oversized recliner that is very comfortable for sleeping.
- Notify us immediately if you may need any special accommodations or assistance. You may be required to have a caregiver present during testing.
- If you are using positive airway pressure therapy (CPAP), bring your mask and headgear. If you have an oral appliance and are having a follow-up sleep study, please bring your oral appliance, adjustment key and/or bands.
- Bring toiletries (hair dryer, toothbrush/toothpaste) and a change of clothing. We provide towels to wash up in the morning.
- If you'd like to bring a healthy snack for the evening or morning, or if you have special dietary needs (e.g., gluten free), please bring snacks with you. We provide coffee and breakfast bars for you in the morning.
- Service dogs trained to assist people with medical disabilities are allowed with prior authorization by our physician.

We have several locations, please be aware and make note of the CSCC sleep center and suite number where your study is scheduled. Please make note of the entrance instructions located in your CSCC patient forms packet for evening entry into the sleep centers. You can also find the patient forms on www.comprehensivesleepcare.com under the **Plan Your Visit** tab.
If you are unable to keep your appointment or if you have an upper respiratory infection causing significant nasal congestion, contact Comprehensive Sleep Care Center at 703-729-3420 at least 3 business days prior to your scheduled appointment to reschedule. As we schedule our technologists in advance for your sleep study and reserve a room, a fee of $150 may be charged for cancellations within the 3 business days of your scheduled sleep study appointment.

If you have any additional questions regarding your sleep study, please give us a call at 703-729-3420 and we will be happy to assist you. Thank you for choosing Comprehensive Sleep Care Center for your sleep health needs; it is our pleasure to be a partner in your care!

IMPORTANT SLEEP STUDY INFORMATION

Please go to our website https://comprehensivesleepcare.com/sleep-study-instructions/ for important instructions that must be followed prior to your sleep study. A $150 fee will be charged for all sleep study appointment cancellations or changes with less than 3 business days' notice. Please be aware of the location and suite you are scheduled for, and note the instructions for entry into the facility:

ARLINGTON: 200 N. GLEBE ROAD #316 ARLINGTON, VA 22203 **Some GPS instructions may try and take you to the back of our building which is incorrect. Please enter through the main gate (parking will be validated). Mr. Wash Car Wash is across the street from our building, we are in the tan colored 10 story building. If coming from North Glebe Road the parking lot is just before reaching 2nd street going north. When coming off Rout 50, Goodwill Retail Store & Donation Center, McDonald and Dunkin Donuts are on the same side of the road as our building. Coming from South Glebe Road, you will pass CVS, 2nd Street, and Knightsbridge Apartments. The gated parking lot will be on your right.** **If after hours, the parking lot gate will be lifted. Please drive to the rear of the building where an intercom is provided near the back-entrance doors. Press the # key associated with the Sleep Center** **on the directory. Await the release of the door, and proceed to elevator, where a technician will arrive to escort you into the facility. If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 2 for Arlington**	
Route 66 East	• Take Route 66 West • Exit 71 onto VA-120 Glebe • Road Turn left onto N. Glebe Road
Route 66 West:	• Take Route 66 East • Exit 71 for Fairfax Drive toward VA-120/VA-237/Glebe Road Merge onto N. Fairfax Drive • Turn right onto N. Glebe Road
Route 50 West:	• Take Route 50/Arlington Blvd. East to Glebe Road exit • Turn Left at the traffic light onto N. Glebe Road Building is on the Left-hand side
Route 50 East:	• Take Route 50/Arlington Blvd. West to Glebe Road exit • Turn Right at the traffic light onto N. Glebe Road Building is on the Left-hand side
CHANTILLY (NEW LOCATION): 4080 LAFAYETTE CENTER DRIVE, #170C CHANTILLY, VA 20151 **Proceed directly to enter the office.** **If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 4 for Chantilly.**	
Route 66 West:	• Take Route 66 West to Exit 53B VA-28 North • Keep right at fork and Merge onto VA-28 North/Sully Road • Take Exit toward Winchester to US-50, Keep Right onto Lee Jackson Memorial Hwy • 1.8 miles turn Left onto Pleasant Valley Rd. • Go .2 miles and turn Left onto Lafayette Center Dr. • Take 1st left in the parking lot and Unit 170C is located on the right-hand side
Route 50 West:	• From Route 50 West • Turn left onto Pleasant Valley Road • Turn left onto Lafayette Center Drive • Take 1st left in the parking lot and Unit 170C is located on the right-hand side
Route 50 East:	• From Route 50 East • Turn left onto Pleasant Valley Road • Turn left onto Lafayette Center Drive • Take 1st left in the parking lot and Unit 170C is located on the right-hand side
DUMFRIES: 3687 FETTLER PARK DRIVE, DUMFRIES, VA 22025 **Proceed directly to enter the office. If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 5 for Dumfries.**	
From 95	• Merge onto 95 North or South (if coming from Springfield) • Take Exit 152 B to merge onto VA-234 N toward Manassas • Turn left onto Van Buren Rd. and go 0.2 miles Turn left onto Fettler Park Dr, Destination will be on the right
From 95 N	• Merge onto 1-95 N towards Washington, DC • Take Exit 152-B and merge onto Dumfries Rd, VA-234 N towards • Manassas
GERMANTOWN: 12321 MIDDLEBROOK ROAD, GERMANTOWN, MD 20874 **If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 7 for Germantown**	
• Take I-895 S, I-95 S, MD-200 W and I-270 N to Middlebrook Road in Germantown. • Take exit 13B from I-270 N Merge onto Middlebrook Road	
• Take I-95 N and I-495 N to Middlebrook Road in Germantown. Take exit 13B from I-270 N • Merge onto Middlebrook Road	

LANSDOWNE: 19441 GOLF VISTA PLAZA, SUITE 230, LANSDOWNE, VA 20176
Press 194413 on the keypad to enter the building. If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 3 for Lansdowne

- Take VA-7 West toward Leesburg/Winchester
- Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne
- Turn left onto Riverside Parkway
- Turn Right onto Golf Vista Plaza

- Take VA-7 East toward Tyson's Corner
- Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne
- Turn left onto Riverside Parkway
- Turn Right onto Golf Vista Plaza

- Take VA-28 North toward VA-7 West toward Leesburg/Winchester
- Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne
- Turn left onto Riverside Parkway
- Turn Right onto Golf Vista Plaza

MANASSAS: 8100 ASHTON AVENUE, SUITE 216 MANASSAS, VA 20109
If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 6 for Manassas.

From areas below Manassas	• 66 E ramp to Washington 0.9 mi, Merge onto I-66 E 3.5 mi • Take exit 47 for VA-234 N/VA-234 toward Manassas 0.1 mi • Slight right onto VA-234 BUS S/Sudley Rd (signs for Virginia 234/Manassas) 0.9 mi • Turn right onto Sudley Manor Dr 0.4 mi • Turn left onto Ashton Ave • Destination will be on the right

NORTH BETHESDA: 6000 EXECUTIVE BLVD, SUITE 604, NORTH BETHESDA, MD 20852
Proceed to the front of the building to park. Call Datawatch outside the building by pressing the button at the front pedestal that houses ADA push pad. This is located directly to the right of the front door. A Datawatch representative will answer and request code for entry. Your entry code is "75337" which is the numbers for "SLEEP". Datawatch will then release the front door, and you should proceed to the elevators and go to the 6th floor. If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 8 for Bethesda

From areas Below N. Bethesda	• Head northwest on I-495 W for 0.9 mile • Keep right at the fork to continue to I-270 N, follow signs for Frederick for 1.4 mile. • Take exit 1A for MD-187/Old Georgetown Rd 0.1 mile • Keep right at the fork, follow signs for Old Georgetown Rd N/MD-187 N and merge onto MD-187 N/Old Georgetown Rd. • Turn left onto Executive Blvd • Turn left. The destination will be on the right.

WOODBRIDGE: 4897 PRINCE WILLIAM PARKWAY, SUITE 102, WOODBRIDGE, VA 22192
If you have difficulty entering the building, please call 703-729-3420 press 1 and then press 1 for Woodbridge.

From 95 S	• Merge onto 95 North • Take Exit 152-B towards Manassas to merge onto VA-234 N • Dumfries Rd towards Manassas – and go 4.0 miles • Follow Spriggs Rd and State Rte. 642/ Hoadley Rd to Prince William Pkwy in Dale City – about 7.3 miles. • Turn right onto Spriggs Rd and go 4.5 miles, • Turn right onto State Rte. 642/Hoadly Rd and go 2.5 miles. • Turn right onto Prince William Pkwy – Destination will be on the right • Make a U-turn onto Hoadly Road/VA-642 E and go 0.1 miles Take the 1st right onto Prince Wm Pkwy/VA-294 S and go 0.3 miles • If you reach County Complex Ct – You've gone about 0.1 miles too far.
From 95 N	• Merge onto 95 South • South Take Exit 163 for VA-642 towards Lorton • Turn right onto VA-642/Lorton Rd for 1.3 miles, slight left onto Lorton Rd, go 0.7 miles • Turn left onto Ox Rd and go for 1.1 miles Continue onto VA-123 S/Gordon Blvd Turn right onto Old Bridge Rd. • Continue onto VA-294 W/Prince • William Pkwy for 1.2 miles, make a U-turn, destination will be on right.

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