Advanced Sleep Medicine Services, Inc.
The Sleep Experts®

New Device Set-up & Resupply CHECKLIST

Please place a check mark next to each item.

Completed by Patient	Verified by Technician	
☐	☐	**Patient Information** (Page 1)
☐	☐	**PAP Device Info & FAQs** (Page 2)
☐	☐	**PAP Success: We're here to help** (Page 3)
☐	☐	**Automatic Shipment of 1st Supply Order** (Page 4)
☐	☐	**Supply Replacement Schedule** (Page 5)
☐	☐	**Terms and Conditions of Service** (Page 6)
☐	☐	**Patient Rights and Responsibilities** (Page 7)
☐	☐	**Acknowledgement of Receipt of Privacy Practices** (Page 8)
☐	☐	**Delivery Ticket (printed and signed by patient & tech)**

Provided by Patient	Received by Technician	
☐	☐	**Primary & Secondary Insurance Cards**
☐	☐	**Driver's License or Photo ID** (or parent's for patients under 18 years old)
☐	☐	**Copay or Deductible**

How would you like to be contacted?

Phone or email	Email only	Phone only	
☐	☐	☐	**Compliance at 3 days, 2 weeks and 90 days**
☐	☐	☐	**Resupply program (contact every 3 months)**

<u>Attention technician</u>: Scan the originals into the patient account and give the original paperwork to the patient to take home.

Technician Signature: _____

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Patient Information

(please complete, even if you have recently had a sleep study)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F

Patient Name_____Social Security Number_____-_____-_____
First Middle initial Last

Home Address_____
Street City State Zip

Date of Birth___/___/____ Home Phone# (____)____-_____ Cell Phone #(____)____-_____

Email Address: _____

Your Occupation_____Employer_____ Work # (____)____-_____
Spouse's Name_____ Employer_____ Work # (____)____-_____
Emergency Contact_____Relationship_____Phone (____)____-_____

Guardian Information *(MUST be completed if patient is under 18 years old)*

*Mother's Name*_____ *Father's Name*_____

Address_____Address_____

Phone # Cell(___)____-____ Home(___)____-____ Phone # Cell (___)____-_____Home(___)____-_____

SSN # ____-____-_____ DOB___/___/_____ SSN # ____-____-_____ DOB ____/____/_____

Employer_____ Employer_____
Address_____ Address_____
Work# (_____)_____ Work# (____)_____

Billing Information

Name of Person Financially Responsible for Account_____
Relationship to Patient_____ SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip

Insurance

Insured by: Self Spouse Father Mother Grandparent Other _____
Primary Insurance Company _____ ID#_____
Policy Holder_____SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip
Secondary Insurance Company _____ ID#_____
Policy Holder_____SSN____-____-_____ DOB___/___/_____
Home Phone # (____)____-_____ Work Phone # (____)____-_____
Home Address_____
Street City State Zip

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Device Information and Frequently Asked Questions (FAQs)

Patient Understands by Re-demonstration the Information Below (check all):

- ☐ Power switch & cord
- ☐ Use of ramp, if applicable
- ☐ Instructed to use grounded outlets
- ☐ Filter use, cleaning & replacement
- ☐ Use & cleaning of humidifier
- ☐ Mask & Headgear assembly & cleaning
- ☐ Exhalation ports/CO2 washout
- ☐ Importance of compliance with prescriptions
- ☐ Equipment to be used during sleep & travel
- ☐ Reviewed re-ordering supplies procedure
- ☐ Patient given operating manual & warranty info.
- ☐ Patient given cleaning instruction
- ☐ Reviewed troubleshooting procedures
- ☐ Follow up procedures reviewed (Page 3)
- ☐ 90-day follow up scheduled: _____
- ☐ Pressure set and verified:_____

Frequently Asked Questions:

1. **What are the complications of treatment?** During the set-up, the technician explained the function, as well as any complications that may arise during the usage of PAP equipment. This includes: dry nose, nose bleed, skin redness/sores on or above the bridge of the nose or forehead, skin irritation, conjunctivitis, sensation or bloating, etc.
2. **Who can I call with questions about my equipment, supplies or therapy?** Please call us during normal business hours from 8AM to 6PM Monday through Friday at 877-775-3377 Option 6 or email papsuccess@sleepdr.com. Please also visit our website www.sleepdr.com for information about therapy, patient education resources and to submit an inquiry online. For billing questions, please call 877-775-3377 Option 4 or email payments@sleepdr.com
3. **What is the equipment agreement?** The equipment remains property of Advanced Sleep Medicine Services, Inc. until it is purchased and paid in full by your health insurance company or self. All supplies and humidifiers are purchased items and cannot be returned. The equipment is accepted in its "as is" condition (having been inspected by the patient /care giver upon delivery). If the equipment is a rental, the patient must keep our equipment in the same condition that it was received except for reasonable wear and tear. The manufacturer will usually warrant the equipment for a period of twelve (12) months (please refer to the equipment manual).

Patient/Caregiver Signature **Relationship to Patient** **Date**

Advanced Sleep Medicine Services, Inc. Clinician **Date**

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The first 90 days: **Your sustained success**

It is our goal to provide the proper equipment, training and support to help you become successful with your PAP therapy. To achieve this goal we will reach out to you at regular intervals over the next 90 days. You can also contact us at any time with questions. We're here to help!

Methods of contact:

PHONE: We will call you during your first 90 days of therapy to offer assistance. Please confirm that we have the correct phone number on file. If you are unable to answer the phone when we call, we may leave a voicemail stating that we are calling from Advanced Sleep Medicine Services, Inc. regarding your therapy. **If you would like to be contacted through email ONLY, please let us know.**

EMAIL: We will email you during your first 90 days of therapy to offer assistance. If you DO NOT wish to be contacted through email, please let us know and we will call you instead. You may update your email address at any time.

After your initial set-up:

1. **Day of** your set-up: Review this paperwork at home. Visit the resources on our website www.sleepdr.com
2. **3 days after** your set-up: We will call you and email you to see how things are going.
3. **2 weeks after** your set-up: We will call you and email you to see how things are going.
4. **90 days after** your set-up: We will call you and email you to see how things are going. You may also be eligible for resupply at this time and you will receive a separate email asking you to submit your order.

Need to contact us?

Phone during business hours (Monday through Friday 8AM-6PM): *call (877) 775-3377 Option 6 or Ext. 608.*
Phone after hours (nights, weekends or holidays for emergencies): *call (877) 775-3377 Ext. 116*
Email: *papsuccess@sleepdr.com*. Our therapists will respond to your email no later than the following business day (usually the same day).
Questions about billing? Speak to a representative in our billing department. You can call (877) 775-3377 Option 4 or email payments@sleepdr.com

Joint Commission Standards for Care:

We are proud to be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) www.jointcommission.org. If you have a complaint or concern about the care that we have provided, please contact the Joint Commission directly by emailing **patientsafetyreport@jointcommission.org** or faxing your concern to 630-792-5636.

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Device Supply Replacement

One of the most important steps in taking charge of your health and maintaining effective therapy is replacing your mask and supplies regularly. Just as you replace your toothbrush, razor blades and many everyday items, it's important for your comfort and health that you replace your mask and supplies as recommended to ensure every component is working at its best. Even minimal replacement can help drive effective therapy.**It is important to reorder when your supplies are depleted or worn** to keep your therapy on course; you will not need to "stock pile" your supplies.

Many insurance plans follow the guidelines from Medicare for regular replacement of supplies. You can review the guidelines online at http://oig.hhs.gov/oei/reports/oei-07-12-00250.pdf. Medicare guidelines suggest replacing your supplies at the following frequency:

Item	Suggested Replacement Frequency	Shipment
Complete Interface: Full Face Mask, Nasal Mask or Nasal Pillow System	Every 3 Months	1 Every 3 Months
Cushions for Nasal Mask or Nasal Pillows	Every 2 Weeks	6 Every 3 Months
Cushions for Full Face Mask	Every 1 Month	3 Every 3 Months
Tubing	Every 3 months	1 Every 3 Months
Filters	Every 2 Weeks	6 Every 3 Months
Humidifier Water Chamber	Every 6 Months	1 Every 6 Months
Chinstrap	Every 6 Months	1 Every 6 Months

Your particular insurance plan may have a different allowance for replacement supplies. This is why we will verify your coverage to determine your allowance before processing your order. Unless you request otherwise, we will send you the maximum number of supplies allowed by your insurance plan. You may purchase additional replacement supplies at our cash prices if you would like more supplies than your plan allows. Please contact us for more information.

Automatic Shipment of 1st Set of Replacement Supplies

☐ Yes, please verify my insurance and ship me the supplies that are covered 90 days after my initial set up and recommended by Medicare.

☐ I would like to receive a full set of replacement supplies recommended by Medicare at 3 months (outlined above) regardless of my insurance coverage. I will pay the cash rate for additional supplies not covered by my insurance.

☐ No, I do not wish to receive an automatic shipment of replacement supplies that are covered 90 days after my initial set up and recommended by Medicare. I will request supplies when I need them.

On-Going Device Supply Replacement Program

Advanced Sleep Medicine Services, Inc. is has developed a simple and flexible program to let you know when you may be eligible for replacement supplies. Most insurance companies will authorize replacement supplies every 90 days.

Here is a brief overview of our resupply program:

1. You will receive a telephone call or email every **90-120 days**

Phone	Email
If we are unable to reach you by phone, we will call again or leave a message. **You will receive about one call per week.**	If we are unable to reach you by email, we will email you again later in the month. **You will receive about one email per week.**
You may press to confirm your order or may press to speak to one of our representatives to complete your order and answer any questions	You will submit your order online.

2. **PLEASE LET US KNOW IF THERE HAVE BEEN ANY CHANGES TO YOUR INSURANCE COVERAGE OR SHIPPING ADDRESS. YOU CAN UNSUBSRIBE FROM OUR PROGRAM AT ANY TIME.**

3. Once you approve your next order or supplies, we will verify your insurance coverage and request authorization, if needed.

4. If we need additional information from you or your physician, we will let you know. Otherwise, you can expect to **receive your supplies at your address on file in no later than two weeks**.

5. We will send you an email with the package tracking number once your supplies have shipped.

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Terms and Conditions of Service

Read Carefully Before Signing

1. Consent to Medical Procedures

Patient consents to the procedures, which may be performed by Advanced Sleep Medicine Services, Inc. in connection with Patient's diagnosis or treatment.

2. Release of Information

Patient hereby authorizes Advanced Sleep Medicine Services, Inc. to furnish to Patient's insurance company all information that the said party may request concerning Patient's diagnosis or treatment. Furthermore, Patient authorizes Advanced Sleep Medicine Services, Inc. to release Patient's sleep study results and report to other caregivers for the purpose of further diagnosis or treatment.

3. Assignment of Benefits

- Your insurance company may send our payment directly to you. Although every effort is made on our part to streamline the payment process with your insurance carrier, there are times when you may receive a check for the services we provided. Should you receive payment, we are requesting that once the check has cleared your financial institution, you contact our business office at the toll free number listed below to settle your account balance. Please keep in mind the amount owed may be more than the face value of the check you receive. This will be due to any co-pays, co-insurance and/or deductibles applied to the claim. Take the time to review your explanation of benefits that accompanies the payment carefully for the total amount owed to our office. Failure to settle any unpaid balance may result in your account being forwarded to a collection agency. **INITIAL:_____**
- Patient understands that Patient is responsible for understanding his/her individual insurance policy and benefits prior to seeking services.
- Patient recognizes that Advanced Sleep Medicine Services, Inc. will bill and attempt to collect from Patient's insurance, as courtesy to Patient and that Patient is financially responsible to Advanced Sleep Medicine Services, Inc. for all charges for services rendered. Patient understands that this may lead to Patient receiving a bill, which may include any deductible, co-payment and co-insurance and agrees to pay such bill. **INITIAL:_____**
- If Patient is an HMO patient, Patient understands that Patient is responsible for any amount attributed to co-pay; deductible or non- covered services, should that apply to Patient's plan. **INITIAL:_____**

4. Automated Collections Calls

I understand that if I do not pay for this product or service upon receipt of an invoice, I may receive autodialed, pre-recorded calls, or both, from or on behalf of Advanced Sleep Medicine Services, Inc. at the telephone or wireless number(s) provided above. I consent to receiving future calls at those number(s) by autodialed calls, pre-recorded calls, or both, and understand that my consent to such calls is not a condition of purchasing any goods or services. **INITIAL:_____**

5. Authorized Signature

Patient certifies that he/she has read this form, understands and agrees with it fully. If this form is signed by anyone other than Patient, then the signee certifies that he/she is Patient's legal representative or is duly authorized by Patient (as the patient's representative) to execute this form for and on behalf of patient and to accept its terms for and on behalf of Patient who shall be bound thereby.

Signature of Patient/Patient Representative: _____

Print Name of Patient/Patient Representative: _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

The rights of patient(s) include, but are not limited to the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Be given information about your rights for receiving testing and treatment.
- Receive a timely response to any reasonable requests you may make for services.
- Be given information about Advanced Sleep Medicine Services, Inc.'s policies, procedures and charges for services.
- Choose your medical providers.
- Be given appropriate and professional quality testing & treatment to you.
- Exercise your rights without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, the source of payment or utilization of services.
- Be free from physical and mental abuse and/or neglect.
- Be given proper identification by name and title of everyone who provides any medical services to you.
- Be given the necessary information so you will be able to give information consent for your service prior to the start of any service.
- Be given complete & current information concerning your diagnosis, treatment, risks, alternatives and prognosis as required by your physician's legal duty disclose in terms and language you can reasonably be expected to understand.
- Participate actively in decisions regarding the medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Confidential treatment of all written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home. Written authorization of the member or authorized legal representative shall be obtained before the medical records can be made available to anyone not directly concerned with the care, except as required by law.
- Review your clinical records at your request.
- Voice your complaint with and/or comment change in medical services and/or staff without being threatened, restrained, and/or being discriminated against.
- Full consideration of privacy concerning your medical care program.
- Case discussion, consultation and treatment are confidential and should be conducted discreetly and to be advised as the reason for the presence of any individual.
- Participate in the consideration of ethical issues that arise in your care.
- Be informed of the actual dollar amount of charges, if any, for which you may be liable.
- Have access, upon request, to all bills for services you have received regardless of whether the bills are paid out-of-pocket or by another party.
- Voice a complaint and/or comment or request a change in medical services and/or staff without being threatened, restrained, and/or being discriminated against. To voice a complaint or comment, you may reach us directly by emailing info@sleepdr.com or calling (877) 775-3377 and requesting the Compliance Officer. You may also file a complaint with the credentialing body, the Joint Commission, online at www.jointcommission.org/GeneralPublic/Complaint or by email at complaint@jointcommission.org or by fax at (630) 792-5636 or by mail at Office of Quality Monitoring, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, IL, 60181. After receiving a complaint, we will contact you, record information regarding your concern, ask you what actions you feel should be initiated, attempt to resolve the complaint to your satisfaction, and report the status back to you within five business days of receiving your communication.

The responsibilities of patient(s) include, but are not limited to the responsibility to:

- Give accurate and complete health information concerning your past illnesses, hospitalization, medication, allergies, and other pertinent items.
- Assist in developing and maintaining a safe and cooperative environment for care & services to be provided
- Refrain from inappropriate behavior during the procedure, including but not limited to any sexual behavior or aggressive behavior.
- Inform Advanced Sleep Medicine Services, Inc. when you will not be able to keep your appointment.
- Participate in the development and update of your treatment plan.
- Follow direction in regards to your testing and treatment.
- Request further information regarding anything you do not understand.
- Contact your physician whenever you notice any unusual feelings or sensations during your plan of service/treatment.
- Contact your physician whenever you notice any change in your condition.
- Give information regarding any concerns and problems you may have to an Advanced Sleep Medicine Services, Inc. staff member.
- Contact Advanced Sleep Medicine Services, Inc. prior to any change of telephone number or address.
- Patient agrees to meet all his/her financial obligations and responsibilities agreed upon with the organization.

Patient Signature:_____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Advanced Sleep Medicine Services, Inc.'s Notice of Privacy Practices and HIPPA policy with the effective date of April 14, 2003. Notice is also available on the website at www.sleepdr.com/HIPAA. I will notify Advanced Sleep Medicine Services, Inc. of any special requests that I may have with regards to my private health information.

_____
Signature of Patient/Patient Representative

_____
Print Name of Patient/Patient Representative

_____
Relationship to Patient

_____
Date