Neil T. Feldman, M.D., P.A.
2525 Pasadena Avenue South
Suite S
St. Petersburg, Florida 33707

Dear Patient:

You have been scheduled for an appointment on _____ at _____AM/PM.

We look forward to seeing you and ask that you take a moment to read over the following information which we hope will be of assistance in planning for your visit.

Preparation for Your Visit:

1. Enclosed you will find a patient information packet which should be completed and brought with you to your appointment.
2. Copies of any pertinent outside medical records should be brought with you, **especially any previous sleep studies.**
3. Please bring all your medications or a list with you to your appointment.

Payment:

For your convenience, we accept most major credit cards. Our insurance staff will be happy to file your charges with your insurance companies. If you do not have a secondary insurance, we appreciate payment of your portion at the time of service.

Please bring your insurance cards and photo ID to the office at the time of your visit, as our staff will make a copy to keep with your chart.

Most managed health care plans, including HMO and PPO plans, require a referral authorization. It is the patient's responsibility to obtain such authorization and bring the referral form for the office visit with them to their appointment. By bringing the referral form to the appointment, you will be able to avoid the necessity of having to reschedule the appointment for a later date.

Many insurance plans have a fixed deductible for the year. Please let our office know if you have not met your deductible for the current year.

We are participating providers with Medicare; therefore, we accept the amount Medicare allows as payment in full. The **patient is responsible for the 20% difference** between the Medicare allowable and payment. This will be collected at the time of your visit.

Cancellations:

If for any reason you find that you must cancel your appointment, we ask that you give our office at least 24 hours prior notice to allow us to schedule other patients whom may be waiting for an appointment.

Questions:

Should you have any questions regarding the above information or about any other aspects of your visit, please feel free to contact our office. We look forward to your visit and will be happy to assist you in any way.

Phone: (727) 360-0853 FLORIDA WATS: 1-800-242-3244 Fax: (727) 367-3735

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your health insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20_____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to chance the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You will recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Service
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but as unable to do so as documented below:

Date:	Initials:	Reason:

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: _____ CELL PHONE: _____

OUT OF STATE ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

ALLERGIES: _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

ARE YOU THE POLICY HOLDER? IF NO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER SS#: _____ **POLICY HOLDER DOB:** _____

DO YOU HAVE A SECONDARY/SUPPLEMENTAL INSURANCE? IF YES, PLEASE PROVIDE THE FOLLOWING:

NAME OF SECONDARY SUPPLEMENTAL INSURANCE: _____

DO YOU HAVE A REFERRAL FOR TODAY'S VISIT? YES _____ NO _____

HAVE YOU EVER HAD A SLEEP STUDY? YES _____ NO _____

IF YES, WHERE? _____

WHO REFERRED YOU? _____

EMPLOYMENT INFORMATION

EMPLOYER: _____

ADDRESS: _____ SUITE #: _____

CITY: _____ STATE: _____ ZIP _____

WORK PHONE: (_____) _____

EMERGENCY NOTIFICATION/NEXT OF KIN

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ APT#: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: (_____) _____ WORK/CELL PHONE: _____

PATIENT SIGNATURE: _____ **DATE:** _____

SleepMed Insomnia Scale

Patient's Name: _____ **Date:** _____

Clinician's Impression: _____

Age: _____ **Epworth Score:** _____

This is a test to assess how you are feeling about your sleep. Answer the following questions rating how you feel about your sleep using a 0-4 point scale. With 0 representing no problem with sleep and 4 representing a big problem with how you feel about the quality of your sleep. 0=no problem with my sleep; 1=slight problem with my sleep; 2=moderate problem with my sleep; 3=moderately severe problem with my sleep; 4=big problem with my sleep affecting all parts of my life.

Please circle the best answer about your sleep for each question:

0=No problem 1=Slight Problem 2=Moderate Problem 3=Moderately Severe Problem 4=Big Problem

1.	Overall describe your satisfaction with your sleep?	0 1 2 3 4
2.	When you sleep in a strange place or a bed other than your own how much trouble do you have trying to fall asleep?	0 1 2 3 4
3.	How much does stress affect your sleep?	0 1 2 3 4
4.	How easy is it for you to fall asleep?	0 1 2 3 4
5.	Is your sleep disturbed with frequent awakenings?	0 1 2 3 4
6.	Can you fall back asleep if you awaken during the night?	0 1 2 3 4
7.	Are you rested the next day after your night's sleep?	0 1 2 3 4
8.	How worried are you that you won't be able to get to sleep?	0 1 2 3 4
9.	Are you getting enough sleep each night?	0 1 2 3 4
10.	How is your overall mood as a result of your sleep?	0 1 2 3 4

Total Score: _____

THE EPWORTH SLEEPINESS SCALE

Name: _____

Today's Date: _____ Your age (years): _____

Your sex (male = M; female = F) _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

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	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Thank you for your cooperation

FATIGUE SEVERITY SCALE (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree to disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire:

During the past week, I have found that:	**Disagree←--------→Agree**
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 7
2. Exercise brings on my fatigue.	1 2 3 4 5 6 7
3. I am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with carrying out certain duties and responsibilities.	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 7

Total Score: _____

Name: _____ Date: _____

St. Petersburg Sleep Disorders Center

HOSPITAL ANXIETY AND DEPRESSION SCALE (HAD)

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the past week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A. **I feel tense or "wound up"**
3 Most of the time
2 A lot of the time
1 From time to time, occasionally
0 Not at all

D **I still enjoy the things I used to enjoy**
0 Definitely as much
1 Not quite so much
2 Only a little
3 Hardly at all

A **I get sort of frightened feeling as if something awful is about to happen**
3 Very definitely and quite badly
2 Yes, but not too badly
1 A little, but it doesn't worry me
0 Not at all

D **I can laugh and see the funny side of things**
0 Most of the time
1 A lot of the time
2 From time to time, occasionally
3 Not at all

A **Worrying thoughts go through my mind**
3 A great deal of the time
2 A lot of the time
1 From time to time, but not too often
0 Only occasionally

D **I feel cheerful**
3 Not at all
2 Not often
1 Sometimes
0 Most of the time

A **I can sit at ease and feel relaxed**
0 Definitely
1 Usually
2 Not often
3 Not at all

D **I feel as if I am slowed down**
3 Nearly all the time
2 Very often
1 Sometimes
0 Not at all

A **I get a sort of frightened feeling like "butterflies" in the stomach**
0 Not all the time
1 Occasionally
2 Quite often
3 Very often

D **I have lost interest in my appearance**
3 Definitely
2 I don't take as much care as I should
1 I may not take quite as much care
0 I take just as much care as ever

A **I feel restless as if I have to be on the move**
3 Nearly all the time
2 Very often
1 Sometimes
0 Not at all

D **I look forward with enjoyment to things**
0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

A **I get sudden feelings of panic**
3 Very often indeed
2 Quite often
1 Not very often
0 Not at all

D **I can enjoy a good book or radio or TV program**
0 Often
1 Sometimes
2 Not often
3 Very seldom

A total: _____ D total: _____

Name: _____ Date: _____

RESTLESS LEG SYNDROME SEVERITY SCALE

Name: _____

Today's date: _____ Your age (years): _____

Your sex (male = M; female = F) _____

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

0 = Non-existent 1 = Mild 2 = Moderate 3 = Severe 4 = Very Severe

Overall how would you rate the RLS discomfort in your legs and arms? _____

Overall how would you rate the need to move because of the RLS symptoms? _____

Overall how severe is your sleep disturbance from your RLS symptoms? _____

Overall how severe is the impact of your RLS symptoms on your ability to carry out your daily affairs, for example, carrying out a satisfactory family, home, social or work life? _____

Overall how severe is your RLS as a whole? _____

Please use this scale for the following question:

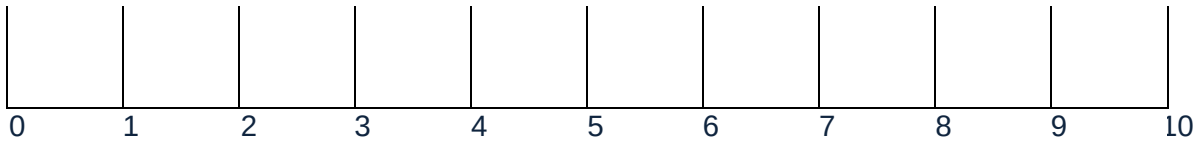
0 = Does not apply	1 = Either complete or almost complete	2 = A moderate amount	3 = A slight amount	4 = Not at all

Overall how much relief of your arm or leg discomfort do you get from moving? _____

SNORING EVALUATION QUESTIONNAIRE

Evaluation of snoring as reported by bed partner:

(Circle a number)



0-3 Occasional soft snoring --- not bothersome to bed partner

4-6 Persistent snoring --- bothersome to bed partner

7-9 Persistent loud snoring --- frequently annoying to bed partner

10 Heroic snoring --- continuous loud snoring not tolerated by bed partner

Patient Name: _____

Date: _____

MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

If you are a member of an HMO, we must ask that you have an authorization or referral from your primary care physician in order for us to see you. If we have not received this by the date of your scheduled visit, we must ask that you reschedule your appointment until such time as we have the proper authorization.

Thank you for your cooperation.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare or any other insurance company benefits be made either to me or on my behalf to Neil T. Feldman for any services furnished to me by that party who accepts assignment. Regulations pertaining to Medicare assignment apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare and/or other insurance company claim.

I understand that my signature request that payment be made and authorizes release of medical information necessary to pay the claim. The signature below authorizes the physician to put "signature on file" on any insurance claim either electronically or on paper. In Medicare and participating insurance companies the physicians agrees to accept the charges determination of the Medicare/other insurance company as the full charge and the patient is responsible for any deductible, co-pay or non-covered charges.

I have read the above payment policy and understand the terms above.

I agree that a photocopy of this form be used in place of the original.

SIGNATURE: _____ **DATE:** _____

Neil T. Feldman, M.D., P.A.
2525 Pasadena Avenue South
Suite S
St. Petersburg, Florida 33707
(727) 360-0853

DIRECTIONS

From Tampa

- I-275 South to St. Petersburg
- Take 5th Avenue N. exit. Turn right off ramp onto 5th Avenue N.
- Turn left on 66th Street N (SPC and Firehouse on corner) – Stay in right lane
- Right lane will veer right and become Pasadena Avenue South
- Continue south on Pasadena Avenue. You will pass Palms of Pasadena Hospital on the right.
- Go over small bridge (Corey Causeway)
- Village Plaza Shopping Center is on the right immediately after bridge. We are located in Suite S.

From Sarasota / Bradenton Area

- I-75 North to I-275 North over the Skyway Bridge
- Take exit #17 (old exit #4) Pinellas Bayway – 1st left exit
- Turn left at light off ramp onto Pinellas Bayway
- Turn right on Gulf Blvd at the end of the Pinellas Bayway
- Turn right on 75th Avenue (diner and car rental on corner)
- Continue over drawbridge, then over smaller bridge. Turn left at caution light into Village Plaza Shopping Center. We are located in Suite S.

From Clearwater / New Port Richey Area

- US 19 South to 66th Street exit
- Continue on 66th Street South – passed Tyrone Mall
- Right lane will veer right and become Pasadena Avenue South
- Continue south on Pasadena Avenue. You will pass Palms of Pasadena Hospital on the right.
- Go over small bridge (Corey Causeway)
- Village Plaza Shopping Center is on the right immediately after bridge. We are located in Suite S.