MEDICAL TREATMENT AUTHORIZATION

I agree to procedures that are requested by me and/or ordered by my physician(s) in connection with my inpatient, outpatient and/or emergency treatment, and medications. If I am a pregnant patient delivering, I consent to hospital care of my infant(s) and consent for release of my private health information needed to care for my infant. You have the right to accept or refuse any care, treatment or service your physician or staff recommends to you. You should ask for information about anything you do not understand or if you need more information.

I acknowledge that I have received written notice of my patient rights, including my right to execute an Advance Directive in accordance with Oklahoma State Law.

☐ Yes ☐ No I have a legal representative.

☐ Yes ☐ No I want to appoint a patient representative to make decisions for me should I become unable to make healthcare decisions. If yes, the following person should make decisions for me: _____ and their contact information is: _____

I understand I have a right to receive information in a manner or language I, and/or my Representative, can understand. I understand interpreter services are available 24 hours a day at no cost.

If my treatment includes treatment groups, I understand that my participation in these groups or classes may involve discussions of my condition in the presence of other patients and I consent to the discussion.

I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I understand that the practice of health care delivery may involve "telemedicine" which is the transfer of my medical data, or exchange of medical information by means of audio, video or data communication to a medical care provider with expertise in a particular area of care. A healthcare provider may be able to assist in the examination and provide additional information about a diagnosis. The physician and staff who have access to your medical information will keep it confidential in accordance with laws and confidentiality policies.

TELEPHONE CONSUMER PROTECTION ACT CONSENT DISCLOSURE

Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.

By providing my telephone number (whether landline or wireless) and/or email address to Tulsa Spine & Specialty Hospital, I expressly consent that Tulsa Spine & Specialty Hospital and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to Tulsa Spine & Specialty Hospital or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or Tulsa Spine & Specialty Hospital's services, including, but not limited to the following:

my hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of Tulsa Spine & Specialty Hospital and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from Tulsa Spine & Specialty Hospital. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

FINANCIAL RESPONSIBILITY

I hereby assign to Tulsa Spine & Specialty Hospital ("TSSH") and any health care provider designated by TSSH to receive such monies, and all rights and interest in insurance benefits and/or entitlements and I direct that all such payments be made directly to TSSH or its designee. Charges for services shall be at the provider's regular rates unless otherwise agreed in writing by TSSH or as required by law.

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if TSSH or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) TSSH's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

A safe is available for safekeeping of valuables. TSSH and its affiliates are released from responsibility for all valuables or personal items, including eyeglasses, dentures, and hearing aid(s) and jewelry that I retain in my possession during my hospital stay or outpatient visit.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENTS OF DISCLOSURE

Tulsa Spine & Specialty Hospital is a physician-owned facility and a list of physician owners is available upon request. Your physician may be an investor in the facility. Your physician receives no compensation from Tulsa Spine and Specialty Hospital for referrals. Please advise us if you desire to be referred to another facility. A physician is usually on site during normal business hours. Our staff is prepared to respond to medical emergencies and on-call physicians are available anytime a physician is not in-house. On-call physicians are available at all times to directly communicate with staff providing patient care and respond to the patient's bedside for any emergent need. My signature below indicates acknowledgement of this information.

☐ Patient ☐ Guardian ☐ Parent of Minor ☐ Power of Attorney	Witness	Date / Time

If not signed, complete the following to explain the reason why:
☐ Emergency situation ☐ Individual refused to sign
☐ Unable to sign
☐ Other: _____

INFORMATION ABOUT YOUR SPECIFIC RIGHTS ABOUT ADVANCE DIRECTIVES

The Patient Self Determination Act directs TSSH to inform you that you have rights under Oklahoma State Laws to make decisions about your care. You have the right to accept or refuse any procedure or care that your physician or staff recommends to you. Your physician will prescribe a treatment plan for you and talk with you about those recommendations including the risks, benefits and alternatives. You should ask for information about anything you do not understand or if you need more information. If at any time you feel your rights are not being respected, your nurse will help you contact the facility representative.

The Oklahoma Rights of the Terminally Ill and Persistently Unconscious Act (Living Will/Appointment of a Healthcare Proxy Law) is a way for a person with decision making capacity to specify future circumstances and conditions in which life sustaining treatment should be withheld. You can appoint another person (aka: surrogate decision maker) to make those decisions for you should you become unable to make decisions for yourself. You can do both. A Living Will does not address your wishes or belongings after death. It is only for certain types of healthcare decisions. A Living Will may apply only to future events or circumstances when the person becomes terminally ill, not necessarily the present. The Oklahoma Do Not Resuscitate Act provides a specific written form called a DNR form that you should sign **only** if you are certain that under no circumstances is cardiopulmonary resuscitation to be provided. A copy of each of these types of Advance Directives can be made available to you and our staff may assist you if you elect to complete an advance directive. If you are scheduled for surgery, you will want to talk with your surgeon and your anesthesiologist about your advance directive prior to surgery. We will not recognize DNR during anesthesia. If considering such documents raises difficult issues for you, our Pastoral Care Department, if applicable, or others are available for more intensive help, please see the front desk or registrar for additional information. You may also have a Durable Power of Attorney for Healthcare. TSSH recommends that all individuals appoint a healthcare Proxy to assure that someone the individual knows/trusts is authorized to make decisions for them if they become incapacitated.

A psychiatric advance directive is akin to a traditional advance directive for healthcare. An individual who is concerned that at some point he/she may be subject to involuntary psychiatric commitment or treatment has the right to execute a psychiatric advance directive. The psychiatric advance directive names another person who is authorized to make decisions for the individual if he/she is determined to be legally incompetent to make his/her own choices. It may include instructions about hospitalization or treatment, alternatives to hospitalization or treatment, the use of medications, types of therapies and the patient's wishes concerning restraint or seclusion. It includes information as to who to notify upon admission, as well as who should not be permitted to visit.

You should keep your advance directive at home with you in a safe place. You should provide a copy to your primary care physician for your medical record in their office. Tell your family where your advance directive is. We recommend that you talk with them about it. **Do not put your advance directive in a safe deposit box with other important papers.** Your family and healthcare providers need access to it readily when you are unable to make decisions for yourself. We will put a copy in your medical record for this hospitalization or treatment.

If you have an advance directive and did not bring it with you, it is urgent that you make arrangements to bring it. In the meantime, our best advice is to complete a document approved by the State of Oklahoma today. Our staff can help you update your current advance directive, or complete a new one. Please tell your doctor and/or nurse about the substance of your advance directive so we can document what you tell us in your medical record. We want to honor your values and wishes about healthcare that you believe is right for you.

COMPLAINTS AND GRIEVANCES

You and/or your representative have the right to express complaints or grievances related to the quality of care received, to have those complaints heard and when possible, resolved. Complaints/grievances should be directed initially to and reviewed by the department and clinical manager and/or director providing the patient care which is the subject of the complaint. If the problem cannot be resolved quickly, it may become a formal grievance handled through the process defined for the facility.

Patients have the right to address their concerns to TSSH Risk Management, 1145 S. Utica Ave, #110 Tulsa, OK 74104, 918-579-2981.

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Fax: 630-792-5636
complaint@jointcommission.org

Oklahoma State Dept of Health
1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.ok.gov/health
405-271-6576

KEPRO BFCC QIO (Area 3)
Rock Run Center
5700 Lombardo Center Drive, Suite 100
Seven Hills, OH 44131
www.keprogio.com
Phone: 216.447.9604
Fax: 844.878.7921

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Tulsa Spine & Specialty Hospital

Sleep Lab Insurance Form
(Include Copy of Patient's Insurance Card)

PATIENT INFORMATION

Last name: First:			Gender: M ☐ F☐
Street address:	City: State:		Zip Code:
Patient/guardian e-mail address:	Social Security Number:	DOB:	Marital Status:
Phone #:	Phone Number Type: ☐Home ☐Cell ☐Other		
Employer:	Employer Phone #:		
Nationality/Race:	Ethnicity:		
If patient is a minor child under age 18, Name of parent / guardian signing patient in:			

Emergency Contact (or Guardian) INFORMATION

☐Emergency Contact /or ☐ Legal Guardian	Gender: M ☐ F☐	Relationship to Patient:	
Last name: First:		Date of Birth:	
Phone #:	Phone Number Type: ☐Home ☐Work ☐Cell		

Primary Insurance: _____ Policy ID#: _____

Name of Subscriber (if other than patient): _____ Subscriber DOB: _____

Insurance Phone Number: _____ Group #: _____

Secondary Insurance: _____ Policy ID#: _____

Name of Subscriber (if other than patient): _____

Insurance Phone Number: _____ Group#: _____

Referring Physician: _____

OFFICE USE ONLY

Date of Study: _____

What Study Was Performed:

95782 PSG PED 5 and under
95783 CPAP PED 5 and under
95810 PSG
95811 SPLIT
95811 CPAP
95805 MSLT/MWT
95806 Home Testing Device

Suspected Disorder: _____ Amount Collected: _____ Bill Patient: _____

CASH _____ CHECK _____ CC _____

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Tulsa Spine & Specialty Hospital

Sleep Lab Pre-Test Questionnaire

Date:_____

Name: _____ Date of Birth: _____ Age: _____

Male Female Height: _____ Weight: _____

MEDICAL HISTORY

Allergies: _____

_____

High blood pressure
Congestive heart failure
Hiatal hernia/reflux
Heart attack
Diabetes
Sensitivity to lotions or makeup
Other significant history: _____

Bypass surgery
Asthma
COPD
HIV/AIDS
Hepatitis type _____

Medications (including herbal, patches, pumps, eye drops, over the counter, and samples):

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Tulsa Spine & Specialty Hospital

Sleep Lab Signs and Symptoms

Name: _____ Date:_____

Please check all of the following signs and symptoms which apply to you:

Heavy snoring

Forgetfulness

Restless sleep

Loss of libido

Irritability

Fatigue

Falling asleep at inappropriate times

Snoring interrupted by silence and then gasping

Anxiety/depression

Trouble concentrating

Short temper

Loss of energy

Morning headaches

Epworth Sleepiness Scale

How likely are you to doze-off or fall asleep in the following situations, in contrast to just feeling 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 select 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 (theatre or 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 traffic	
Total	

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Tulsa Spine & Specialty Hospital

Sleep Lab Fall Risk Assessment

Name: _____ Date:_____

Please complete all fields below:

Have you had a fall in the last 12 months	Yes	No
How many falls have you had?		
Did any of these falls result in serious injury?	Yes	No
Do you require assistance getting in and out of bed?	Yes	No
Do you require assistance getting to and from the restroom?	Yes	No
Do you require a: Walker Wheelchair	Cane	

Please note Tulsa Spine and Specialty /Zoellner Medical Group staff members do not provide assistance. If you require assistance getting in and out of bed, getting to and from the restroom, or walking you will need to bring a responsible caregiver with you to your scheduled sleep study (Example: Spouse, appointed caregiver, friend, or adult child).

Failure to bring a responsible care giver may result in your study being cancelled.

_____
Patient Written Name

_____ _____
Name Date

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Tulsa Spine & Specialty Hospital

Sleep Lab Release and Consent Form

1. I hereby authorize my health care provider, Tulsa Spine and Specialty Hospital, hereinafter "Provider," to furnish to my insurance company, or other person or entity involved in my treatment with a full report of my case history, examination, diagnosis, treatment, prognosis, or other medical/billing information in regard to my treatment by Provider.
2. I hereby give my consent for video monitoring and recording for the professional use in diagnosing and recommending treatment.
3. Some insurance companies, including Blue Cross Blue Shield, send payment directly to the patient for the sleep study. This money is the insurance company's portion for the sleep study. This is not reimbursement for any out-of-pocket expenses you might have paid. These checks must be forwarded over to Tulsa Spine and Specialty Hospital within 10 days of receiving. These checks are often adjoined to the patients' EOB (Explanation of Benefits).
4. If for any reason you are unable to make your appointment, you must notify our office within 48 hours of your scheduled appointment. Failing to cancel or reschedule in a timely fashion will mean you will be expected to pay $150 fee. This fee is simply to offset the expense of the sleep technician who is limited to only two (2) patients per night and the sleep center, which by design can only schedule a maximum of five (5) patients per night. Any cancellation fees collected would be in addition to any fees that you might be required to pay.
5. Insurance guidelines regarding Obstructive Sleep Apnea and sleep studies are very stringent. If you do not meet criteria for both diagnostic and treatment during your initial sleep study, you may be required to return in-lab for a non-consecutive second night titration study. This is billed as a separate study, and any applicable co-pays and/or coinsurances will be the responsibility of the patient. You will be notified if this applies to your individual situation.
6. I am aware that I may choose a provider for Durable Medical Equipment (DME) as provided by the law. DME equipment related to a sleep treatment can include but not limited to CPAP/Bi-Level machines, masks hoses, and possibly oxygen supplies. Should the need for DME equipment arise, please check below the course of the action you wish Tulsa Spine and Specialty Hospital to provide.

_____I accept the DME provider chosen by Tulsa Spine and Specialty Hospital

_____I choose to use my own provider

Name of Provider: _____

Contact Name: _____ Phone: _____

_____ _____

Patient's Signature **Date**

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Tulsa Spine & Specialty Hospital

Sleep Lab

Interpreting Physician Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third-party payors to the interpreting physician. The interpretation fee is separate from the actual sleep study monitoring fee, and Tulsa Spine and Specialty Hospital is unable to provide specific information regarding this charge. For an estimated out-of-pocket amount, contact your insurance company regarding coverage of the 26 modifier or component for a professional interpretation fee of a sleep study.

I hereby authorize the interpreting physician to furnish to my insurance company or its agent(s) any information concerning my medical history, services rendered or treatment needed to process claims.

Technical Component Assignment of Benefits

I understand the same agreement shall apply to billing the technical aspect of my sleep study. A technical fee is separate from the actual interpretation fee. These fees are negotiated by your insurance carrier and labeled "allowable amount." I authorize Tulsa Spine and Specialty Hospital to bill for the technical component of my sleep study.

Insurance and Billing

I am aware that efforts to pre-certify the procedure with my insurance company have been made and my estimated out-of-pocket for the sleep study has been discussed with me prior to my sleep study. I agree payment and billing arrangements have been made and acknowledge that I am responsible for my co-payment, coinsurance and/or unmet deductible amounts required by my insurance company and rejections. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including collection agency fees.

A photocopy of this assignment is to be considered as valid as the original.

Patient Signature **Date**