GHALY
sleep center

6713 Collamer Road
East Syracuse, NY 13057
Phone: 315-463-0421
Fax: 315-463-0466

Thank you for scheduling a new patient consult at The Ghaly Sleep Center.

You are scheduled for _____at_____

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME SO YOU CAN BE CHECKED IN AND READY FOR THE PROVIDER.

Please bring photo ID, insurance card, and COMPLETED paperwork to your appointment if mailed out. New patient paperwork will be texted/emailed to you to complete electronically through our program, Yosi prior to your visit and saves directly to your chart. Copays will be collected AT THE TIME OF SERVICE if not paid online prior. If you are responsible for a copay and are unable to pay at the time of service, you will be asked to reschedule your appointment. Please note that **if you arrive AFTER your scheduled appointment time, you may be asked to reschedule. If you need to cancel or reschedule your appointment, please give 24 hours notice. A parent or guardian MUST accompany a minor for their appointment.**

If you have any questions or concerns, please contact our office 315-463-0421.
Thank you,
The Ghaly Sleep Center

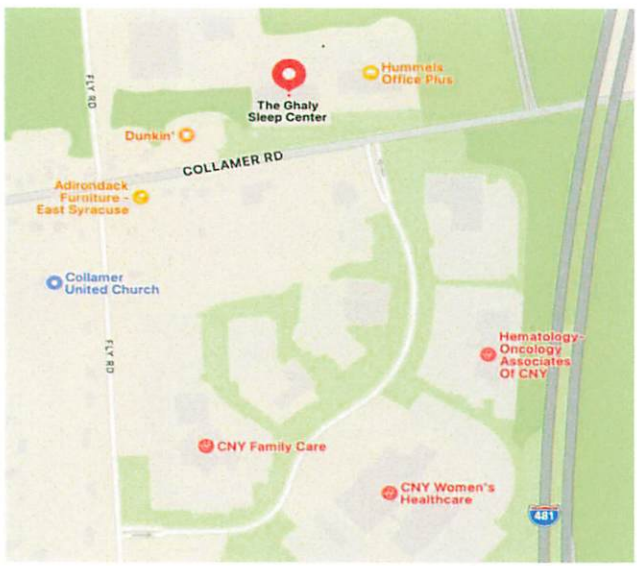
We are conveniently located right off Route 481, in the same building as James Alexander Law.

From the East: Take Route 298 West towards Fly Rd. We are the 2nd building on the right after the 481on-ramp.

From the North: Take Route 481South to Exit 7, then take a right onto Route 298.We are the 2nd building on the right.

From the South: Take Route 481North to Exit 7, then take a right onto Route 298. We are the 2nd building on the right.

From the West: Take Route 298 East past Fly Rd. We are on the left just past Dunkin Donuts.



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SLEEP LAB REGISTRATION

Please completely fill out the information below.

Last Name:_____ FirstName:_____ Date:_____

Address: _____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

DOB:_____ Age: _____ Sex: Male □ Female □

Parent/Guardian Name if a minor:_____

Height:___ ft._____in. Weight:_____lbs. Current Working Status: Working □ Retired □ Disabled □

Email Address: _____ Check to enroll.in Patient Portal □

Circle one: Single Married Divorced Widowed Separated

Emergency Contact:_____ Contact Phone: _____

Referring Physician:_____ Phone:_____

Address: _____

Medical Insurance: Insurance Carrier: _____ Policy Holder:_____

Relationship:_____ DOB:_____ Policy Holder's Employer:_____

Policy ID#:_____ Group#:_____

Secondary Insurance Carrier:_____ Policy ID#:_____

Medications: _____

Past Medical History/ Surgeries: _____

Allergies: _____

Do you Smoke: Yes ___ No___ Former___- If yes, when did you quit?_____
Did you receive the flu vaccine: Yes_No_____-If yes, approx. when_____
Did you receive the COVID vaccine: Yes___No___-If yes, approx. when and which one_____
Did you receive the Pneumonia vaccine (60 and older): Yes___No___-If yes, approx. when_____
Do you have any advance directives? (i.e. health care proxy): Yes___ No___
Do you have a medical power of attorney? Yes___No___

• *6713 Collamer Road, East Syracuse, NY 13057* •

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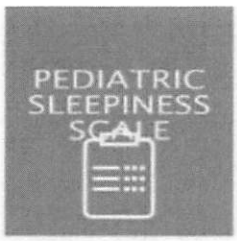

EPWORTH SLEEPINESS SCALE FOR CHILDREN & ADOLESCENTS

Name:_____ DOB:_____ Date:_____

This questionnaire was developed to determine the level of daytime sleepiness in pediatric patients. You should help your child complete the questionnaire and review his or her responses with a doctor.

Over the past month, how likely have you been to fall asleep while doing the things that are described below (activities)? Even if you haven't done some of these things in the past month, try to imagine how they would have affected you.

Use the following scale to circle the number that best describes what has been happening to you during each activity over the past month.

0 Would ***never*** fall asleep

1 ***Slight*** chance of falling asleep

2 ***Moderate*** chance of falling asleep

3 ***High*** chance of falling asleep

Activity	Chance of Falling Asleep			
Sitting and reading	0	1	2	3
Sitting and watching TV or a video	0	1	2	3
Sitting in a classroom at school during the morning	0	1	2	3
Sitting and riding in a car or a bus for about half an hour	0	1	2	3
Lying down to rest or nap in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly by yourself after lunch	0	1	2	3
Sitting and eating a meal	0	1	2	3
Total Score:				

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Authorization to Treat Minor in Absence of Parent/Legal Guardian

Sleep Insights Medical Associates PLLC dba Ghaly Sleep Center must receive permission from a child's parent or legal guardian, prior to providing treatment(s) for preventative care, injury or illness that is non-life threatening. This form provides the legal permission to (depending on the minor's age) either treat without any adult present (Section A) or with a designated adult present (Section B).

Patient's Name: _____ Date of Birth: _____

Note: A parent/legal guardian MUST be present for a minor patient's first visit with Ghaly Sleep Center.

Section A (ONLY for minor at least 16, but not yet 18 years old)

Authorization to treat your minor in case you or your designated representative are unable to accompany your child to one of his/her visits: I, _____, grant Ghaly Sleep Center permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

NOTE: If you do not wish to add a designated representative then please leave below Section B blank and sign/date at the bottom.

Section B (for minor under 18 years old)

Delegation of authority for the treatment of the above mentioned minor to the designated representative indicated below: I, _____, grant Ghaly Sleep Center permission to assess and treat the aforementioned minor in the presence of either of the following adults, who is authorized to approve treatment:

Name: _____ Relation to the minor: _____

Name: _____ Relation to the minor: _____

I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

This authorization:

☐ is effective on: _____.

☐ is effective from _____ to _____.

☐ is effective for this visit only (date of appointment): _____.

☐ is effective until otherwise revoked in writing.

Print Name: _____ Date: _____

Sign Name: _____

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HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). Sleep Insights Medical Associates PLLC Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

Sleep Insights Medical Associates PLLC needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below. We will witness your signature.

_____

Print Patient Name (and Guardian name if applicable) Patient Date of Birth

I give my consent for Sleep Insights Medical Associates PLLC to use and disclose my PHI to carry out TPO. With this consent Sleep Insights Medical Associates PLLC may mail items or call my home (or other alternate locations) to facilitate treatment, payment, and healthcare operations. They may leave messages concerning healthcare information (such as appointment reminders, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

__ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to Sleep Insights Medical Associates PLLC to also specifically speak with:

____ Spouse: _____

____ Relative: _____

____ DOT or employer-directed physician: _____

____ Other: _____

Sleep Insights Medical Associates PLLC may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

_____

_____

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

_____

Signature of Patient Date

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New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through.

the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit

Health Connections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change mv decision at any time bv completing a new form.
D 1. I **GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).
D 2. I **DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in* a *medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Health-Connections and the consent process:

1. How Your Information May be Used. Your electronic health information will be used only for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - Quality Improvement Activities. Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL your electronic health information available through Health Connections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This
   information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted
diseases	

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories. health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Health Connections. You can obtain an updated list at any time by checking Health Connections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You If You Give Consent**. Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain.
   public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to Whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the
   Health Connections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re- disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If Health Connections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Health Connections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision, they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form

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PATIENT RESPONSIBILITY AGREEMENT

The doctors and staff of Ghaly Sleep Center / Sleep Insights Medical Associates PLLC appreciate the confidence you have shown in choosing us to provide for your medical care. We are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

The patient (or patient's guardian, if a minor) is responsible for payment for his/her treatment and care.

- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of service. We accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover.
- ***ONLY patients with high deductible commercial plans who: 1.) do not have secondary insurance or Medicaid and 2.) have not met their deductible must pay the following at time of service:***
  - $150 is due at time of service for all consultations.
  - $50 is due at time of service for all follow-up appointments.
  - $100 at the time of scheduling for all sleep studies.

  Any overpayments will be applied to future dates of services or refunded in full.
- Patients may incur and are responsible for the payment of the following additional charges:
  - A $40 fee for all returned checks.
  - A $50 fee will be applied towards all no-show office visits and $100 fee for all no-show sleep studies.

  While we understand there may be times when you miss an appointment due to emergencies or obligations, Sleep Insights requires a 24-hour notice for all cancelled appointments.
- Patients may be discharged from the practice if two (2) or more appointments are no showed.

INSURANCE

The following are the patient's responsibility:

- Patients must bring their insurance card to each visit.
- Notify our office of any changes to insurance/address/phone numbers.
- If there is a change in insurance and we are not notified prior to the change or we do not accept the new insurance, patient may be responsible for payment in full.
- Know copays, benefits and coverage and determine if doctor(s) are in-network providers prior to first visit.
- Pay for any allowed amounts not covered by insurance.

If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.

PATIENT AND EMPLOYEE SAFETY

We must assure a safe work environment for our employees. Sexual advances and/or physical assault of any kind upon any of our staff members will result in immediate discharge from our clinic. Discharge in these cases will be at the sole discretion of the treating provider.

CELL PHONE USE CONSENT

Sleep Insights Medical Associates PLLC may contact the patient's cell phone regarding appointments, test results, billing inquiries and any other matter associate with the patient's account. Cell phones may not be used for personal audio or video recording of office visits or in-lab testing.

EQUIPMENT RETURN

I understand that I am responsible to return any medical equipment that was loaned to me by Sleep Insights Medical Associates in a timely manner. All equipment should be returned within 1-2 weeks of receipt unless otherwise specified. I will be responsible for the full price of the unit it if it is not returned. This includes home sleep testing, oximetry, actigraphy and PAP loaner machines.

AUTHORIZATION TO ASSIGN BENEFITS TO GHALY SLEEP CENTER / SLEEP INSIGHTS MEDICAL ASSOCIATES PLLC

I authorize my Payer(s) to pay directly to Ghaly Sleep Center / Sleep Insights Medical Associates PLLC any benefits due under the terms of my health care plan(s), for services provided by Ghaly Sleep Center / Sleep Insights Medical Associates PLLC. I understand Ghaly Sleep Center / Sleep Insights Medical Associates PLLC reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Ghaly Sleep Center / Sleep Insights Medical Associates PLLC on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Sleep Insights Medical Associates PLLC.

AUTHORIZATION FOR TREATMENT

I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my physician(s) or other Ghaly Sleep Center / Sleep Insights Medical Associates PLLC medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physicians, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Sleep Insights Medical Associates PLLC to release all medical information as necessary to:

- All Payers* for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Ghaly Sleep Center / Sleep Insights Medical Associates PLLC entities for the purpose of providing information regarding the services and goods of Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Sleep Insights Medical Associates PLLC may not condition treatment, payment, enrollment, or eligibility for benefits on my agreeing to this provision.

I authorize Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and my insurer(s) to share my past, current and future health, treatment and account records about services I have received from Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

I have read, understand, and agree to the provisions of this Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Ghaly Sleep Center / Sleep Insights Medical Associates PLLC reserves the right to change or amend this statement at any time and at its discretion.

X

Signature of Patient/Responsible Party	Print Name	Date

*For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

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SURESCRIPTS CONSENT FORM

I authorize Sleep Insights Medical Associates PLLC dba Ghaly Sleep Center to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Sleep Insights Medical Associates PLLC dba Ghaly Sleep Center providers with prescribing, assessing health conditions and recommending appropriate treatment.

[ ] I hereby opt in of providing access to any health information available in a health information exchange.

[ ] I deny consent.

_____ _____

Signature of Patient **Date**

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in a stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. If your insurance ID card says "fully insured coverage," you **can't** give written consent and give up your protections not to be balance billed for post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. If your insurance ID card says "fully insured coverage," you **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

Services referred by your in-network doctor
If your insurance ID card says "fully insured coverage," surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protection to apply.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed and your coverage is subject to New York law ("fully insured coverage"), contact the New York State Department of Financial Services at (800) 342-3736 or surprisemedicalbills@dfs.ny.gov. Visit http://www.dfs.ny.gov for information about your rights under state law.

Contact CMS at 1-800-985-3059 for self-funded coverage or coverage bought outside New York. Visit http://www.cms.gov/nosurprises/consumers for information about your rights under federal law.