PATIENT DEMOGRAPHIC/INTAKE FORM

Welcome To Our Office	NEW PATIENT INFORMATION		Date: (MONTH/DAY/YEAR):			
PATIENT'S NAME (PLEASE PRINT)	S.S.#	Marital Status S / M / W / D / Sep	Sex M / F	Birth Date	Age	Religion (Optional)

STREET ADDRESS PERMANENT TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE # EXT. # / CELL PHONE NO.
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
DRUG ALLERGIES, IF ANY:	EMAIL ADDRESS:		
SPOUSE / PARENT'S NAME/NEXT OF KIN	HOW ARE YOU RELATED?	TEL NUMBER:	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #
EMPLOYER'S STREET ADDRESS	CITY AND STATE		ZIP CODE
*SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE	ZIP CODE	HOME PHONE #

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF I DO NOT GIVE AT LEAST 24 HRS NOTICE OF CANCELLATION I MAY BE BILLED THE FULL FEE FOR MY MISSED APPOINTMENT. CALLS MADE AFTER HOURS THAT NEED TO BE RETURNED BY PHYSICIAN ARE CHARGED A $50.00 FEE.

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE		ZIP CODE	HOME PHONE #
IF INSURANCE COMPANY (NAME OF POLICY HOLDER) ☐	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE
WRITE IN NAME OF INSURANCE COMPANY PLEASE ☐	EFFECTIVE DATE		POLICY #	
TELEPHONE NUMBER OF INSURANCE COMPANY:				
HOW DID YOU FIND OUT ABOUT US?				

WAS THIS A RESULT OF AN ACCIDENT? ☐ YES ☐ NO	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY/TELEPHONE NO.
	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)	DATE X-RAYS TAKEN	

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

Signature________________________________ Date ________________________________

New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my health care, Appleton Clinic / Sleep and Fatigue Treatment Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and can be provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Sleep and Fatigue Treatment Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Sleep and Fatigue Treatment Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Sleep and Fatigue Treatment Center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

____ ____________________

Patient's Signature (authorized representative signing for the patient) Date

THIS PAGE IS FOR
OFFICE USE ONLY

[ ] Consent received by ______________________________ on ____________________

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on ____________________.

TPO CONSENT FORM

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Disclosure of Protected Health Information Log

Date	Time	Name of Requestor (Include Business Information)	Reason for Request	Information Requested* (BE SPECIFIC)	Known?	Approved By/D (If Applicable
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

CES-D: *Name:* ______________________ *Date:* ______________________

Below is a list of the ways you might have felt or behaved. Circle the corresponding number to indicate how often you have felt this way DURING THE PAST WEEK.

0 Rarely or None of the Time *(Less than I Day)*
1 = Some or a Little of the Time (1-2 *Days*)
2 = Occasionally or a Moderate Amount of Time (3-4 *Days*)
3 = Most or All of the Time (5-7 *Days*)

DURING THE PAST WEEK:	*Rarely or None of the Time*	*Some or a Little of the Time*	*Occasionally or a Moderate Amount*	*Most or All of the lime*
1. I WAS BOTHERED BY THINGS THAT USUALLY DON'T BOTHER ME	0	1	2	3
2. I DID NOT FEEL LIKE EATING; MY APPETITE *WAS* POOR	0	1	2	3
3. I FELT THAT I COULD NOT SHAKE OFF THE BLUES EVEN WITH HELP FROM *MY* FAMILY OR FRIENDS	0	1	2	3
4. I FELT THAT I WAS JUST AS GOOD AS OTHER PEOPLE	0	1	2	3
5. I HAD TROUBLE KEEPING MY MIND ON WHAT I WAS DOING	0	1	2	3
6. I FELT DEPRESSED	0	1	2	3
7. I FELT THAT EVERYTHING I DID WAS AN EFFORT	0	1	2	3
8. I FELT HOPEFUL ABOUT THE FUTURE	0	1	2	3
9. I THOUGHT MY LIFE *HAD* BEEN *A* FAILURE	0	1	2	3
10. I FELT FEARFUL	0	1	2	3
11. MY SLEEP WAS RESTLESS	0	1	2	3
12. I WAS HAPPY	0	1	2	3
13. I TALKED LESS THAN USUAL	0	1	2	3
14. I FELT LONELY	0	1	2	3
15. PEOPLE WERE UNFRIENDLY	0	1	2	3
16. ENJOYED LIFE	0	1	2	3
17. I HAD CRYING SPELLS	0	1	2	3
18. I FELT SAD	0	1	2	3
19 I FELT THAT PEOPLE DISLIKED ME	0	1	2	3
20. I COULD NOT GET "GOING"	0	1	2	3

TOTAL: _______

Appleton Clinic / Sleep and Fatigue Treatment Center
2499 Glades Rd., Suite 110, Boca Raton, FL 33431
Tel: (561) 450-8328 Fax: (561) 450-5817

FATIGUE SEVERITY SCALE

Using the following scale, circle the most appropriate number in the chart.

1 = Completely Disagree 4 = Neither Agree now Disagree 7 = Completely Agree

DURING THE PAST WEEK, I HAVE FOUND THAT:	*Completely Disagree*			*Neither Agree/ Nor Disagree*			*Completely 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:

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NAME:_________________________ DATE: _____________
(Month/Date/Year)

ZUNG ANXIETY SCALE

How often has each of the following statements applied to you during the last 2 weeks?

0 = None or a little 1 = Some of the Time 2 = Good Part of the Time 3 = Most, or All, of the Time of the time

	None of the Time			Most of the time
1. I FEEL MORE NERVOUS AND ANXIOUS THAN USUAL	0	1	2	3
2. I FEEL AFRAID FOR NO REASON AT ALL	0	1	2	3
3. I GET UPSET EASILY OR FEEL PANICKY	0	1	2	3
4. I FEEL LIKE I'M FALLING APART AND GOING TO PIECES	0	1	2	3
5. I FEEL THAT EVERYTHING IS ALL RIGHT AND NOTHING BAD WILL HAPPEN	0	1	2	3
6. MY ARMS AND LEGS SHAKE AND TREMBLE	0	1	2	3
7. I AM BOTHERED BY HEADACHES, NECK AND BACK PAINS	0	1	2	3
8. I FEEL WEAK AND GET 'TIRED EASILY	0	1	2	3
9 I FEEL CALM AND CAN SIT STILL EASILY	0	1	2	3
10. I CAN FEEL MY HEART BEATING FAST	0	1	2	3
11. I AM BOTHERED BY DIZZY SPELLS	0	1	2	3
12. I HAVE FAINTING SPELLS OR FEEL LIKE FAINTING	0	1	2	3
13. I CAN BREATHE IN AND OUT EASILY	0	1	2	3
14. I GET FEELINGS OF NUMBNESS AND TINGLING IN MY FINGERS AND TOES	0	1	2	3
15 I AM BOTHERED BY STOMACH ACHES OR INDIGESTION	0	1	2	3
16. I HAVE TO EMPTY MY BLADDER OFTEN	0	1	2	3
17. MY HANDS ARE USUALLY DRY AND WARM	0	1	2	3
18. MY FACE GETS HOT AND BLUSHES	0	1	2	3
19. I FALL ASLEEP EASILY AND GET A GOOD NIGHT'S REST	0	1	2	3
20. I HAVE NIGHTMARES	0	1	2	3

Total Score: _____________

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ **DATE:**________________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	___ +	___ +	___

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ______

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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Sleep and Fatigue Treatment Center
Drug of Abuse Testing Consent Agreement

This drug of abuse testing consent agreement is made between the patient listed below and Sleep and Fatigue Treatment Center. Patient reserves the right to be randomly drug screened when the doctor suspects possible involvement or influence of drugs and if the patient is taking a controlled substance. I understand that I am responsible for the cost of the drug test which is $50.00.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

______________________________	____/____/________
Patient's Name (Printed)	Date of Birth
______________________________	____/____/________
Patient's Signature	Today's Date

Sleep and Fatigue Treatment Center
Cancellation and No Show Policy

I.) Cancellation of an Appointment

Please be courteous and call promptly if you are unable to attend an appointment. This time will be reallocated to someone who needs to come in to see Dr. Appleton. If it is necessary to cancel your scheduled appointment, we require that you call or email us 24 business hours in advance. If you call for a refill on one of your medications that results in the cancellation of your follow up appointment with the doctor, you will be charged in full for the missed appointment.

II.) How to Cancel Your Appointment

To cancel appointments, please call **(561) 450-8328** or feel free to email us at **reception@sleepandfatigue.com**. If you do not reach a member of the office staff, you may leave a detailed message on the company voice mail.

III.) No Show Policy

A "No Show" is someone who misses an appointment without canceling it 24 business hours in advance of your scheduled appointment. (Example: your appointment is at 3 pm on Tuesday. You need to call or email us by 3 pm on Monday). No-shows inconvenience those individuals who need to come in to see Dr. Appleton. A failure to present at the time of a scheduled appointment will be recorded in your chart as a "No Show". I agree to pay in full for any missed appointment.

_____________________________ ____/____/________
Patient's Name (Printed) Date of Birth

_____________________________ ____/____/________
Patient's Signature Today's Date