OPTIMAL SLEEP HEALTH
STEVEN J. SCHEER, M.D., DABSM
2020 Cattlemen Rd., suite 400
Sarasota, FL 34232
Ph: (941)342-3400 • Fax: (941)342-3445

WELCOME TO OPTIMAL SLEEP HEALTH

Thank you for choosing Optimal Sleep Health and welcome to our office. Dr. Steven Scheer is a Board-Certified specialist in Sleep Medicine, treating patients with a variety of sleep disorders, including sleep apnea, snoring, restless legs, insomnia, and narcolepsy.

We ask that all new patients arrive for the first appointment at least 10-15 minutes prior to scheduled time with Dr. Scheer to ensure proper documentation has been obtained and processed by the staff.

What to bring with you to your appointment:
Insurance card(s); Driver's license/Photo ID; Authorization/Referee (It is the sole responsibility of the patient to provide this office with all insurance information and a referral/authorization from your primary care doctor if this is required.); Previous Sleep Study Reports (if applicable).

*Our Contact Details:**Mailing Address**: Optimal Sleep Health
2020 Cattlemen Road, Suite 400
Sarasota, FL 34232

Phone: (941) 342-3400 Fax: (941) 342-3445

Office Hours: Monday thru Thursday 8:00 am to 5 pm
We are open Friday 8:00 am to 12 pm for administrative work

If your appointment with Dr. Scheer is in Venice or North Port, you will still need to send all correspondence to the address above and direct all phone calls to our Sarasota office at (941) 342-3400.

Office Locations and Patient Care Hours:

Sarasota 2020 Cattlemen Road Suite 400 Sarasota, FL 34232	Sarasota from 1-75: Take Bee Ridge Road Exit West. At the first light make a right onto Cattlemen Road. About a mile and a half; we are located on the left hand side of the street across from Fifth Third Bank. From Bahia Vista St: South onto Cattlemen Road and half mile down on the right. From Fruitville Road: Take Cattlemen Road south 1.7 miles past Bahia Vista on the right.
Venice 199 Center Road Venice, FL 34285	From North Port: Take Tamiami (41) north, right fork onto the business Bypass. Turn right on Center Rd (by Perkins Restaurant), turn left onto Ogden, then immediate left into medical park. From Englewood: Take 776 north to 41 north, onto Business bypass, then right onto Center Rd (by Perkins Rest.), left on Ogden, then immediate left into medical park. From Osprey/Nokomis: South on 41, left fork at Bypass, south on 41, left on Center Rd (by Perkins Rest.), left on Ogden and immediate left into medical park.
North Port 13815 Tamiami Trail North Port, FL 34287	Located on Tamiami Trail off S. Biscayne Drive, in the North Port Medical Center, the Millennium Group. From North Port and Port Charlotte, take 41 N/Tamiami Trail, tum Right onto South Biscayne Drive, Turn Right onto Tamiami Trail.

**Dr. Scheer encourages each patient to bring the spouse/bed partner to the consultation.*

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PATIENT REGISTRATION INFORMATION

Date: _____

Social Security #: _____

_____

First Name **M.I.** **Last Name** **Suffix** **Maiden name**

Sex: _____M _____F Date of Birth: _____ Birth Place (State) _____

Legal Marital Status: Single _____ Married _____ Divorce _____ Widow_____

ETHNICITY
☐ Decline to specify

☐ Hispanic or Latino
☐ Not Hispanic or Latino

RACE
☐ Decline to Specify
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific
☐ White

Language: ☐ Decline to specify ☐ English

Mother's Maiden Name: _____
First Last

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____ Ext: _____

Second Address/Alternate Billing Address: _____

City: _____ State: _____ Zip Code: _____

Referred by: _____

Work Information - Occupation: _____Industry: _____ Employer: _____Phone:_____

Employer's Address:_____Zipcocde_____City_____State_____

Personal and Emergency Contacts:

Name: _____Phone: _____Relationship_____

Name: _____Phone: _____Relationship_____

Preferred Pharmacy Name: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Name _____

MEDICARE PATIENTS: Medicare does not always pay your bills first. Please indicate which insurance pays your bills first by providing the insurance information in the Primary Insurance section of this form.

Primary Insurance (insurance company that pays first): _____

Claims Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Group Number: _____ Insurance ID#: _____

Policy Began: _____

Primary Insurance Subscriber/Policyholder information:

_____

(First Name) (M.I.) (Last Name) (Suffix)

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship of Policy Holder to Patient: _____ Sex: _____M _____F

Date of Birth: _____ Social Security #: _____

Home Phone #: (_____) _____

Insured's Employer _____ Employer Insurance Plan _____Yes _____ No

Secondary Insurance (insurance company that pays second) _____

Claims Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Group Number: _____ Insurance ID#: _____

Policy Began: _____

Secondary Insurance Subscriber/Policyholder Information:

_____

(First Name) (M.I.) (Last Name) (Suffix)

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship of Policy Holder to Patient: _____ Sex: _____M _____F

Date of Birth: _____ Social Security #: _____

Home Phone #: (_____) _____

Insured's Employer _____ Employer Insurance Plan _____Yes _____ No

OPTIMAL SLEEP HEALTH
STEVEN J. SCHEER, M.D.

HIPAA/PATIENT CONTACT CONSENT

Last Name **First Name** **M.I** **Date of Birth** (MM/DD/YYYY)

I wish to be contacted in the following manner (please check all that apply):

_____ Home telephone ( ) _____

_____ Work telephone ( ) _____

_____ Cell phone ( ) _____

_____ Mail _____

_____ Email _____

_____ Secure Message (Patient Portal)

May we leave the following information on your answering machine/voice mail?

Appointment reminder Yes _____ No _____

Billing Information Yes _____ No _____

Medical information Yes _____ No _____

I give permission to share appointment, billing or medical information with the following persons named below:

_____

_____

_____

Signature of Patient/Parent or Legal Guardian Date

OPTIMAL SLEEP HEALTH
STEVEN J. SCHEER, M.D.

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT FOR MEDICAL SERVICES & TREATMENT

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by Steven Scheer, M.D. and ancillary providers.

FINANCIAL AGREEMENT

Insurance Verification: I understand it is my responsibility to present my insurance cards and photo ID upon each and every appointment.

Consent for Photo documentation: I understand that photo documentation could be used and would become part of my medical record.

ASSIGNMENT OF BENEFITS

In the event that I am entitled to physician benefits of any and all types, I assign such benefits to Steven Scheer, M.D. for services rendered to me. I authorize payment directly to Steven Scheer, M.D. of all such insurance benefits payable to me. Such insurances includes, but not limited to, private commercial insurance, auto liability insurance, or any governmental programs such as Medicare, and authorizes Steven Scheer, M.D. to release medical information to such insurance providers as necessary to satisfy conditions for payment of the assigned benefits. I certify that the information given regarding my insurance is adequate and current.

I accept responsibility for the remainder of charges that are not fully reimbursed by my insurance company which are the amounts deemed to be my responsibility by my Managed Care Plan per the contracted fee schedule. I understand that payment of these amounts will be due upon receipt of a billing statement, which could include coinsurance (a percent applied by your insurance company, deductible or non-covered charge per your plan.)

The co-payment should be paid at time of service. Per our contract with your insurance company we are required to collect your co-payment at time of service

Medicare only patients: we will collect the Medicare approved 20% coinsurance based the CPT code at check out.

Statements

The initial statement for patient's responsibility will be billed and due in full within 30 days. We understand some balances may be more than a patient can pay at one time. Our office is very understanding of this issue and would be happy to offer you a monthly payment plan if needed for larger balances. Please contact billing directly to set up your monthly agreement at 941-342-3400 Option 7.

If payment is not received within 30 days of the date of the final billing, finance charges may begin to accrue at the maximum rate allowable by law. In addition such balance may be turned over for collection activity, at which time the undersigned shall be liable for collection agency's fees and expenses. The undersigned understands that Steven Scheer, MD has the right to examine credit bureau files for financial information regarding collection of unpaid debt.

Insufficient Funds: Returned checks will have a **$35.00** check fee added and must be paid prior to any pending appointments.

Insurance Precertification

I understand that, before service is rendered, I personally am responsible for any required notification to my insurance company to obtain authorization for treatment. If this is not done, insurance benefits may be reduced and I am responsible for all charges not covered by my insurance. I understand that Optimal Sleep Health may assist me with obtaining authorization.

Outside facility or outpatient Services to include Sleep Lab, or durable medical supplier

I understand that Dr. Scheer refers out to several Sleep lab facilities and DME companies, and that my information, including insurance information, will be shared with these facilities. I understand that these facilities bill separately for any services provided directly by them.

NOTICE OF PRIVACY PRACTICES

I have received a copy of the revised Notice of Privacy Practice that describes how Optimal Sleep Health, Steven Scheer, MD, may use and disclose my health information, and also describes my rights regarding my health information.

Print Patient Name or Legally Authorized Representative	**Print Name of Guarantor of Payment Date**
Signature of Patient or Legally Authorized representative	**Signature of Guarantor of Payment Date**

OPTIMAL SLEEP HEALTH
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NO-SHOW AND CANCELLATION POLICY

Our schedule fills up quickly. We try to see new patients and follow-up patients in a timely manner. When we schedule your appointment, we reserve a block of time for you to meet with Dr. Scheer. **A no-show, or failure to cancel the appointment 24 hours ahead,** creates a space that could be given for another patient who wishes to see Dr. Scheer sooner if space were to become available. To help minimize last minute cancellations and no-shows, we have established the following policy: **A $50.00 fee will be charged to any patient who fails to come for the scheduled appointment, unless the patient calls in to cancel the appointment 24 hours before the office visit. Monday appointments must be cancelled by 12:00 noon on the Friday prior to your Monday appointment**. Exceptions to this policy are for emergencies or approved extenuating circumstances.

REQUEST FOR PRESCRIPTION REFILL

Please allow at least 7 days to process any medication requests. Please call in advance of running out of your medication(s) to process refill(s).

Referring Physicians

We feel that keeping an open communication with your referring physician and/or other physicians who provide medical care to you is essential to your overall health and well-being. If you would like us to communicate with other specialists that you see regarding your care, please assist us by checking the appropriate specialty and writing the physician's name, address, and phone number.

Referring physician: _____
Name Address Phone Number

Primary Care Physician: _____
Name Address Phone Number

Cardiologist: _____
Name Address Phone Number

Other: _____
Name Address Phone Number

_____
Print Name **Date**

_____
Signature

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MEDICAL HISTORY AND PHYSICAL FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Female Male (circle)

Main reason(s) for needing a sleep evaluation and date of onset:

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation. **0 = Would never doze off 1 = Slight chance of dozing off**

2 = Moderate chance of dozing off 3 = High chance of dozing off

Situation	Chance of dozing off				
Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting, inactive in a public place (theatre, church, school, meeting...)	0	1	2	3	
Passenger in a car for 1 hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch; no alcohol	0	1	2	3	**TOTAL**
In a car, stopped for a few minutes in traffic	0	1	2	3	_____

_____

Sleep Habits

Usual bed time: _____ Usual wakeup time: _____

Trips to the bathroom per night: _____

Number of naps per week: _____ Duration of naps: _____

Use of sleeping equipments: CPAP__; BiPAP__; ASV__; Oxygen__; Dental Device_; Special Bed_

Snoring heard by partner? Yes - No

Name _____

How loud is your snoring? (Circle) MILD MODERATE LOUD

Does it wake you up? Yes - No

Apnea observed by partner? Yes - No

Do you ever wake up choking/gasping/short of breath? Yes - No

Have you had previous sleep studies? Yes - No When? _____

Sleep study result: _____ What doctor? _____

Previous sleep study treatment: (circle) CPA Dental Surgery Nothing

Sleep Movement: Restless Leg ___; Teeth Clenching ____; Head Rocking____;

Acting Out Dreams_____; Sleep Walking_____; Other_____

History

Occupation/Employment: _____

Marital Status (circle): Married; Divorced; Widowed; Single; Living w partner

How often do you exercise? _____

Do you have any physical limitations that prevent you from exercising (circle):

Pain; Shortness of Breath; Exhaustion; Other _____

Social History

Caffeine: Yes - No

If Yes: Cups of coffee a day ___ / a week ____

Cups of tea a day___ / a week ____

Cups of caffeine soft drinks a day____ / a week ____

Cups of Power drinks a day___ / a week _____

When is the latest in the day that you usually consume caffeine drinks? _____

Tobacco History: Have you ever smoked? Yes__ No__

If Yes: Smoking since (year):_____; Per day: _____; Quit smoking (year) _____

Alcohol: Yes - No

If Yes: (circle) daily weekly monthly occasionally

Number of drinks: _____

Beer bottles: _____; Wine glasses: _____; hard drinks: _____

Do you drink close to bedtime? Yes - No

Recreational Drugs: (marijuana, cocaine, amphetamines, etc) : Yes - No (specify): _____

Name _____

Family Medical History

Please write any disease that a family member(s) has/have or died of:

	Has/have	Died of
Mother		
Father		
Sibling(s)		
Children		
Grandfather		
Grandmother		
Paternal Aunt		
Maternal Aunt		
Paternal Uncle		
Maternal Uncle		

Family Demographics: Mother Living___ Deceased___ Age_____

Father Living___ Deceased___ Age_____

Sister Living___ Deceased___ Age_____

Brother Living___ Deceased___ Age_____

Child Living___ Deceased___ Age_____

Past Medical History

Do you have any of these symptoms, or have you ever been diagnosed with any of the following conditions? Please circle yes or no.

Yes – No : High Blood Pressure
Yes – No : High Cholesterol
Yes – No : Thyroid Problems
Yes – No : Emphysema/ Shortness of breath/Cough/ Asthma
Yes – No : Stroke / Head Trauma
Yes – No : Neurological Disorders/ Numbness/Tingling/Weakness
Yes – No : Epilepsy / Seizures
Yes – No : Visual problems
Yes – No : Hearing Loss
Yes – No : Heart Disease / Heart Attack / Arrhythmia
Yes – No : Palpitations/Chest Pain
Yes – No : Trouble Swallowing/ Sore Throat / Large Tonsils
Yes – No : Nasal Congestion/Deviated Septum
Yes – No : Hepatitis/AIDS/HIV
Yes – No : Arthritis / Fibromyalgia / Chronic Pain
Yes – No: Depression / Anxiety/ ADD/ADHD
Yes – No : Diabetes – Type I/Type II
Yes – No : Heartburn/Reflux/Irritable Bowel/ Ulcer history
Yes – No : Kidney Disease/Urinary Infections/Prostate problems
Yes – No : Skin Disease
Do you ever have?: Night Sweats ___; Early AM Headaches ___; Memory or Concentration Problems___

Have you recently been hospitalized? Yes - No If so, when/why? _____

Name_____

Please list all surgeries:

Surgery Performed **Year**

_____ _____ _____

_____ _____ _____ _____

_____ _____ _____

List of Medications (Please continue on back if needed or enclose a copy of your medication list)

_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____
_____ Times/day _____ Dosage: _____

Over the counter Sleep Aids and supplements:

_____

_____

_____

_____

Known allergies:

_____

_____

Height: _____ **Current Weight:** _____ **Weight 1 yr ago:** _____ **Weight 5 yrs ago:** _____

Any additional comments or information that you would like to bring to the physician's attention:

_____

_____