Location: Pinehurst Medical Clinic Sleep Disorder Center
245 Page Road
Pinehurst, NC 28374

Dear New Patient of Pinehurst Medical Clinic Sleep Disorder Center,

We are pleased to welcome you as a new patient of Pinehurst Medical Clinic's Sleep Disorder Center. To ensure the best possible experience during your upcoming visit, please take note of the following:

1. Plan on arriving at least 15 minutes prior to the scheduled time of your appointment to avoid delays.

2. Bring your medical insurance card(s) and medications with you on the day of your appointment.

3. Complete your new patient paperwork before coming to your appointment. If you need a paper copy mailed to you, please call (910) 695-2161 to make this request. Please allow at least 2 business days for your request to be processed, and an additional 5-7 business days to receive a paper copy in the mail.

4. If previous medical records are needed our office may contact you to make arrangements to obtain records.

5. If you are a new patient being seen for Sleep Medicine and have seen a previous doctor for sleep issues, please bring all sleep records and studies you have had in the past to your appointment. You can also have these records faxed prior to your appointment by sending them to (919) 292-1205.

6. Once you've established care, for urgent needs after hours, please call the office and follow the instructions to reach the provider on call.

Pinehurst Medical Clinic Pulmonology & Sleep Medicine kindly ask you and anyone coming with you to your appointment to ***refrain*** *from wearing scented lotions, perfumes, and/or cologne as many of our patients are sensitive to these products. If you or any persons with you do not adhere to this policy, you may be asked to reschedule.*

We look forward to seeing you soon. In the event you need to cancel your appointment, we ask that you give us at least 24 hours' notice.

Sincerely,
PMC Sleep Medicine
(919) 292-1201

Pinehurst Medical Clinic

REGISTRATION FORM

PATIENT INFORMATION

Patient's Name:		
Address:		
City:	State:	Zip Code:
Home Phone:		
Mobile Phone:	Other Phone:	
Patient e-mail:		
Date of Birth:	Sex: □ Male □ Female	
Marital Status: □ Married □ Single □ Divorced □ Widowed □ Unknown		
Race: □ Black/African American □ Asian □ White □ American Indian/Alaskan Native □ Native Hawaiian/Other Pacific Islander □ Unknown		
Ethnicity: □ Hispanic □ Non-Hispanic		
Primary Language: □ English □ Spanish □ Other: ____________________		
Social Security Number:		
Primary Care Doctor:		

EMPLOYER INFORMATION

Employment Status: □ Employed □ Self-employed □ Retired □ Disabled □ Student □ Unemployed
Employer Name:
Employer Telephone:

EMERGENCY CONTACT

Emergency Contact Name:
Relationship to Patient:
Emergency Contact Phone:

RESPONSIBLE PARTY INFORMATION

Parent/Guardian Name:		
Address:		
City:	State:	Zip Code:
Telephone:		

INSURANCE INFORMATION

Insurance Company:	
Policy / Group Number:	Effective Date – From:
Subscriber Name:	Patient's Relationship to Insured:
Subscriber SSN:	Subscriber's DOB:
Subscriber Employer:	Subscriber's Sex: □ Male □ Female

Please Arrive 15 Minutes Before Your Scheduled Appointment Time

Pinehurst Medical Clinic Sleep Medicine Questionnaire

Name:______________________________ Date: ________________

Referring Doctor: ______________________________

Why are you seeing a sleep specialist:______________________________

____

Please help us find out about you by filling out the "Patient" side of this form

PATIENT

When did your sleep issues begin? ____________

Any trouble sleeping as a child or teenager? ☐ Yes ☐ No

If you have tried any sleep medications which ones?

__________ __________ __________

__________ __________ __________

Are you currently using a sleep aid and which one? ____________

Tell us about your sleep schedule:

What is your weekday bedtime? ________ wake up? ________

weekend bedtime? ________ wake up? ________

How long does it take for you to fall asleep?______minutes______hrs.

What time do you eat dinner? ______________

What snacks/drinks do you typically consume after dinner?

____

What do you do after dinner? ______________________________

____

Do you do any of the following activities **in bed** before bedtime?

Circle all that apply: Read Watch TV Play Video Games

Talk on the Phone Use Cell Phone, Tablet, or Computer

How many times do you wake up in the middle of the night? ______

able to fall back to sleep easily? ☐Yes ☐ No ☐ Not always

How often do you need to get up to urinate during sleep? ________

What do you do when you are unable to sleep? ______________

____

....

Do you work outside the home? ☐ Yes ☐ No

If yes, what are your hours? ______________

Do you work weekends? ☐ Yes ☐ No Shift Work? 1st 2nd 3rd

Retired? ☐ Yes ☐ No

Disabled? ☐ Yes ☐ No

CLINICIAN

BMI>35

Age>50

Neck:

Gender:

Mallampati:

PATIENT	CLINICIAN

Do you take daytime naps? ☐ Yes ☐ No
How many per week? ___________
How long do they last? ___________
What time of the day? ___________
Are the naps refreshing? ☐ Yes ☐ No
Do you doze (unintentional falling asleep) in the afternoon or evening?
☐ Yes ☐ No

....

Do you ever experience restlessness in your legs before bedtime?
☐ No ☐ Yes: how many days per week? _________
If yes, does it disrupt your sleep? ☐ Yes ☐ No
Do you move or kick your legs while sleeping? *(Bed partner complains)*
☐ Yes ☐ No ☐ Don't know

....

Currently smoking? ☐ Yes ☐ No
Do you drink alcohol beverages routinely at night? ☐ Yes ☐ No
If yes, how many? __________
Do you drink caffeinated beverages (coffee, tea, soda)? ☐ Yes ☐ No
How many before 6pm?_________How many after 6pm? _________
Do you drink any type of energy drinks? ☐ Yes ☐ No
If yes, how many and what times? ________________________
If you use any recreational drugs, please list: ________________________

....

Have you ever felt the sudden loss of strength (arms/legs) in response to emotional experiences? ☐ Yes ☐ No
Have you ever felt paralyzed when you first wake up or when falling asleep? ☐ Yes ☐ No
Do you ever have vivid or menacing visions while you are falling asleep? ☐ Yes ☐ No
Do you walk in your sleep? ☐ Yes ☐ No
Talk in your sleep? ☐ Yes ☐ No
Do you have nightmares? ☐ Yes ☐ No
Do you ever accidentally urinate in bed? ☐ Yes ☐ No

....

Are you sleepy or tired during the day? ☐ Yes ☐ No
How many days of the week? _______
When did it start_____weeks______months_____years
Is it worsening? ☐ Yes ☐ No
Have you had close calls or accidents when driving due to sleepiness?
☐ Yes ☐ No
Have you had any issues with concentration or memory loss?
☐ Yes ☐ No

PATIENT	CLINICIAN

*Please rate your chances of **falling asleep** in the following situations using the scale below:*

0 – would never doze
1 – slight chance of dozing
2 – moderate chance of dozing
3 --- high chance of dozing

_____ Sitting and reading
_____ Watching television
_____ Sitting inactive in a public place
_____ While a passenger in a car without a break
_____ Laying down to rest in the afternoon when circumstances permit
_____ Sitting and talking to someone
_____ Sitting quietly after lunch (without alcohol)
_____ In a car, while stopped in traffic for a few minutes

*Rate the severity of your daytime **fatigue**:*

0---1-----2----3- - 4- - 5----6- - 7- - 8----9- - 10

None Moderate Severe

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No
If yes, are you on CPAP therapy? ☐ Yes ☐ No
If no, please answer the following:

Do you snore? ☐ Yes ☐ No
If yes, is it loud? ☐ Yes ☐ No
Is it getting worse? ☐ Yes ☐ No
Do you snore on your back? ☐ Yes ☐ No In a chair? ☐ Yes ☐
NoDo you gasp or choke during sleep? ☐ Yes ☐ No
Has anyone ever noticed you stop breathing during sleep?
☐ Yes ☐ No
Do you wake with a dry mouth? ☐ Yes ☐ No ☐ Sometimes
headache? ☐ Yes ☐ No ☐ Sometimes

Health Questionnaire:
Allergies:_______________________________ ☐ None

Please list any current or past illnesses/medical conditions you have been treated for:

1. ____________________ 4. ____________________
2. ____________________ 5. ____________________
3. ____________________ 6. ____________________

Please list all current medications: *If PMC patient, this is not needed.*

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Pinehurst Medical Clinic

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Pinehurst Medical Clinic to disclose the following information from the medical records of:

Patient Name: ______________________________________Date of Birth: __________________

Address: ____

Telephone: ______________________________Patient Number: ___________________________

Covering the period(s) of health care:
From ______________________ to ______________________

From ______________________ to ______________________

Information to be disclosed:

☐ Complete health record(s), including all images (x-rays, photographs, etc.)
☐ Complete health record(s), excluding all images
OR
Select from the following (check as many as apply):

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ History and Physical Examination
- ☐ Laboratory Tests
- ☐ Consultation Reports
- ☐ X-ray reports
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- ☐ Mental health care or services
- ☐ Psychotherapy Notes
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Photographs, videotapes, digital or other images

☐ Other (please specify)
____
____

This information is to be disclosed to the following individual or entity for the purpose of:
____
____

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Name:___________________________________ Relationship: ____________________________

Address:____

Telephone: ____________________________
The patient or the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of ____.
   Initials: ______________

b. I understand that I may revoke this authorization at any time by notifying Pinehurst Medical Clinic in writing, but if I do it won't have any effect on any actions Pinehurst Medical Clinic took before it received the revocation.
   Initials: ______________

c. I understand that Pinehurst Medical Clinic cannot make me sign this authorization as a condition to receive treatment from Pinehurst Medical Clinic except:

   (i) when Pinehurst Medical Clinic provides me with research-related treatment; or

   (ii) when Pinehurst Medical Clinic provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
   Initials: _________________

Pinehurst Medical Clinic, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(*Form MUST be completed before signing*)

____
Signature of Patient or Representative

____
Date

____
Print Name

____
Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

____

____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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Pinehurst Medical Clinic

Pinehurst Medical Clinic Patient Payment Policy

1. Payment is due at the time of service. This may include deductibles, co-payments, co-insurance, and services not covered by an insurance company.
2. Payments may be made by cash, check, money order, MasterCard, Visa, Discover, or American Express.
3. You may receive a separate bill for services provided by a FirstHealth Cardiology & Specialty Clinic provider at PMC.
4. Patients without insurance may be eligible to receive a discount for payment in full on the day services are provided. You will need to speak to a Patient Account Representative.
5. A No-Show Charge will apply should you fail to keep your scheduled appointment without giving us a 24-hour or greater advanced notice of your cancellation. Three (3) consecutive appointment cancellations and/or no-shows may result in dismissal from Pinehurst Medical Clinic. The No-Show fees are $75 for a new patient office visit, $25 for an established patient office visit, and $25-$250 for procedure/testing appointments.
6. Patients may be charged a fee for the completion of forms.
7. Patients who feel their level of income is not sufficient to enable them to pay the amount they owe may apply for financial assistance by completing an application. This application may be obtained from one of our financial representatives or by calling Financial Services at 910-295-9392. Please note in general, financial assistance is extended only to patients whose family income is at or below 150% of the federal poverty limits.
8. Balances due after your insurance has paid will be reflected on billing statements sent to the patient's, or responsible party's, address. The amount due on the statement is due in full upon receipt. If you are unable to pay the amount in full it is your responsibility to call Financial Services to discuss making other payment arrangements.
9. Unpaid charges billed to your insurance will appear on your statement indicating they are pending a response from the insurance company. If a charge has been filed with your insurance for over 60 days without a response, please contact your insurance company. If the charge remains unpaid it may become your financial responsibility.
10. It is important to remember that health insurance coverage and plans vary, and not all charges will be covered or paid in full. If your insurance denies a service or does not pay in full, you are responsible for paying the remaining balance.
11. Services received as a result of an accident are to be paid promptly. We do not allow additional time for payment where the accident results in a lawsuit or insurance case.
12. If your health insurance plan requires a preauthorization or referral, it is your responsibility to ensure it is obtained before services are received.
13. New patient visits are coded per industry standards based on whether the patient is new to the specialty or subspecialty. Reference the following link for additional information: https://www.aapc.com/blog/41276-new-vs-established-patients-whos-new-to-you/
14. Failure to pay a balance due promptly may result in one or more of the following:
    a. Your account may be referred to a collection agency,
    b. Your past due status may be reported to the applicable credit bureaus,
    c. Your ability to receive services from Pinehurst Medical Clinic may be jeopardized.

We encourage those who have questions regarding this policy document or any aspect of their bill to contact us at (910) 295-9391 or toll-free at (866) 327.3159.

Pinehurst Medical Clinic

Access Your Health Information Online

Where you need it, when you need it.

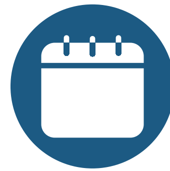
Powered By FollowMyHealth

An all-in-one personal health record & patient portal that lets you access your health information online & on the go!

View test & lab results

Receive email care reminders

Send & receive secure online messages



Request appointments

Request Rx refills

Set up proxy accounts for children & dependent adults

To get started with a new account, give receptionist your email. To log in to an existing account, scan below.

Questions?

Call (910) 235-3380 or email fmhsupport@pinehurstmedical.com