Maria J. Sunseri, M.D. FAASM
PRACTICE OF SLEEP MEDICINE
Diplomate, American Board of Sleep Medicine
American Board of Psychiatry and Neurology (ABPN)
ABPN, Subspecialty of Clinical Neurophysiology
American Board of Clinical Neurophysiology
ABMS, Subspecialty of Sleep Medicine

4815 Liberty Avenue
Mellon Pavilion, Suite 120
Pittsburgh, PA 15224

Main office: 412-781-2023
Appts/Billing: 412-315-5380
Office Fax: 412-727-7842

www.agoodnightssleep.net

Dear:

You have been scheduled for evaluation of your sleep problem with Dr. Sunseri on _____ @ _____ am / pm. The initial appointment will take between 40-60 minutes. Enclosed please find our sleep questionnaire, patient information form and your HIPPA confidentiality packet. **Please complete all forms and bring them with you to the appointment.** Please note that several of these pages have questions on the back as well. If you arrive and the forms have not been completed, you may be asked to reschedule.

Please bring your insurance cards and photo ID.

All office co-payments are expected to be paid at the time of service. We accept cash, checks, and credit card/debit card/health spending account cards.

The office is located in the Mellon Pavilion, which is connected to Western Pennsylvania Hospital. We recommend parking in the garage located between South Millvale Street and Gross Street (see attached directions sheet). **The garage costs $3.00 but you must bring your parking ticket to the office for it to be stamped in order to receive the discount.** Take the catwalk on the top level of the garage across to the Mellon Pavilion. It's easy to locate the catwalk if you park on the top level of the garage; otherwise, you must take the garage stairs or elevator to the top level. In the Mellon Pavilion, follow the M arrows on the wall to the M elevator (to the left) and go to the 1st floor. Exit elevator to the left and follow signs to Suite 120.

Please feel free to contact our office with any questions or if you need directions. You may also visit us on the web at www.agoodnightssleep.net. We must receive a **24-hour notice** for appointment cancellations or you may be charged a fee.

Thank you.
Maria J. Sunseri, M.D. L.L.C.

Maria J. Sunseri, M.D., LLC
Practice of Sleep Medicine
4815 Liberty Avenue
Mellon Pavilion, Suite 120
Pittsburgh, PA 15224

OFFICE POLICY

This is an agreement between Maria J. Sunseri, M.D., LLC, a medical office, and the patient named on this form. In this form the words "you", "your", and "yours" mean the patient. The words "we", "us", and "our" refer to Maria J. Sunseri, M.D., LLC. By signing this form, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. By signing this agreement, you are agreeing to pay all services that are received.

1) INSURANCE & COPAYMENTS

Current insurance and prescription cards, along with proper identification (driver's license) must be presented at each visit. If we are contracted with your insurance company, we must follow our contract and their requirements. It is your responsibility to contact your PCP at least 1 week prior to a scheduled appointment to request an insurance referral if one is required. **Copays are expected at the time of service**. We accept cash, check, certified money order, credit/debit/health spending account cards. We will bill your insurance company as a courtesy to you, but it is your insurance company who makes the final determination of your eligibility. **You agree to pay any portion that your insurance company does not cover.** If you do not have insurance, or we are not contracted with your insurance company or in your health plan's network, you must pay by cash, check or credit card on the day that services are rendered unless other arrangements have been made and approved prior to services being rendered.

2) KEEPING APPOINTMENTS

You will be charged a $25.00 fee (1st occurrence) if you do not show for your appointment and/or do not call within 24 hours of the appointment to cancel or reschedule. You will be charged $50.00 for the second occurrence. The no show and late cancellation fees are not billable to any insurance company and are the sole responsibility of the patient. Repeatedly cancelling or not showing for appointments without giving 24 hours' notice could be cause for discharge from the practice.

3) MEDICATIONS

Patients are required to bring a current medication list to each visit. All patients that are prescribed medication by Dr. Sunseri must be re-evaluated at least every 3 to 6 months or as requested. Failure to keep appointments can result in medications not being prescribed and/or called into the pharmacy.

4) REFILLS & INSURANCE AUTHORIZATIONS

It is your responsibility to give our office one to two weeks' notice when requesting prescription refills and prescription insurance authorizations. Insurance authorizations are lengthy and time consuming. A delay in contacting us for a refill or authorization will result in a delay in the prescription being refilled.

5) FORMS

Please do not leave forms or send forms for Dr. Sunseri to fill out. Certain exceptions do apply but please understand that this should be treated as a privilege, not a right.

6) PRIVACY

An updated Notice of Privacy Practice is displayed at the registration desk in the office and a copy can be sent to you upon your request. It can also be accessed on our website at www.agoodnightssleep.net. By signing below, you are confirming that the Notice of Privacy Practice has been made available to you.

I have read the above information and understand the office policy of Maria J. Sunseri, MD.

Patient's printed name: _____

Signature: _____ Date:_____

( ) Patient ( ) Parent Other _____

PATIENT INFORMATION FORM

Patient Last Name: _____ **First Name**: _____ **MI**:___

Gender:_____ Date of Birth:_____ SS#_____

The following questions are required by as per the government's Meaningful Use guidelines*

(Please circle one)

Marital Status: Single / Married / Divorced / Widowed **Are you Hispanic or Latino?** Yes / No / Refuse to Report
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / Refuse to Report / White

Home Address:_____City:_____State:_____ Zip:_____

Primary contact ph# for daytime use _____ (please circle) HOME / CELL / WORK

Alternate ph # _____(please circle) HOME / CELL / WORK

Referring Physician: _____Phone #_____ Fax#: _____

Address:_____City:_____State:_____ Zip:_____

PCP Name or Other Physician that you would like to receive a Report:_____

Address:_____City:_____State:_____ Zip_____
Phone#:_____ Fax:_____

Name of Primary Insurance Co :_____
Address:_____City:_____State:_____ Zip:_____
Phone #: ( )_____ID#_____ _____ Group#:_____
Subscriber Name:_____ Subscriber DOB._____Subscriber SS#_____
Address:_____City:_____State:_____Zip:_____
Relationship to Patient: _____
Subscriber's Employer:_____Address:_____
City _____State: _____Zip:_____ Phone #:_( )_____

Name of Secondary Insurance Co :_____
Address:_____City:_____State:_____ Zip:_____
Phone #:( )_____ID#_____ Group#:_____
Subscriber Name:_____ Subscriber DOB._____Subscriber SS#_____
Address:_____City:_____State:_____Zip:_____
Relationship to Patient: _____
Subscriber's Employer:_____Address:_____
City _____State: _____Zip:_____ Phone #:_( )_____

How did you hear about Dr. Sunseri? ( ) TV ( ) Internet ( ) Newspaper ( )Other_____

Assignment of Benefits & Electronic Pharmacy Authorization

I hereby authorize my insurance and /or medigap benefits to be paid directly to the physician furnishing the services and also authorize the physician to release any information required in the processing of this claim. I understand that I am financially responsible for any non-covered services, deductible fees and office co-payments. A Copy of this authorization is a valid as the original.

Signature:_____**Date**:_____**Time:**_____
( ) Patient ( ) Parent ( ) Other_____

Maria J. Sunseri, MD.L.L.C.
Practice of Sleep Medicine

I understand that a copy of the updated Notice of Privacy Practice is available to me at the office, on the website at www.agoodnightssleep.net, or can be sent to me upon my request.

Print Patient Name:_____

Signature of Patient:_____

Date:_____

****

HIPPA CONSENT TO RELEASE INFORMATION

LIST THE NAME/PHONE NUMBER OF THOSE INDIVIDUALS WHOM OUR OFFICE MAY DISCUSS YOU MEDICAL HISTORY AND /OR CONDITION WITH.

Name:_____ Phone #_____

Relationship_____

Name:_____ Phone #_____

Relationship_____

Name:_____ Phone #_____

Relationship_____

Who is your medical decision Maker in the Case of an Emergency?

Name:_____ Phone Number:_____

Is Dr. Sunseri and/or her office staff permitted to leave an outlined message on your answering machine or Voice Mail regarding your medical treatment, test results and /or Appointment dates: Yes No

Is Dr. Sunseri and/or her office staff permitted to leave a discrete message for you at your Place of Employment Yes No

This information may be changed and /or the consent may be revoked by means of written consent from the patient.

Signature:_____ Date:_____

Maria J. Sunseri, M.D. L.L.C.
PRACTICE OF SLEEP MEDICINE
Sleep-Wake Questionnaire

Name:_____ Date of Birth:_____
Height:_____ Weight: _____Male _____Female _____ Age:_____
Occupation: _____Shifts: yes____no_____hours_____
If male-neck size/shirt size: _____
If female-approximate date of last menstrual cycle: _____ Postmenopausal: yes___no____
Do you smoke? Yes____no_____. How much? _____ packs/day. How long?_____ quit when?_____
How much alcohol do you drink?_____
Married_____ Single_____ Divorced_____ Widowed_____

Main sleep complaint:
___difficulty falling asleep ____difficulty staying asleep ____difficulty getting up in the morning
___unrefreshing sleep ____ difficulty staying awake during the day
___unwanted behaviors during sleep ___ snoring ___ gasping ___ snorting ____ choking
____ have you or anyone else thought you stopped breathing for several seconds or more in your sleep?

When did your sleep problems first start?_____

Have you had a sleep study? ___yes ____no
If yes, where, when and what were the results?_____

Usual sleep habits:
Do you snore? Yes____No____ Loud____ Moderate_____ Soft_____
Do you have to use antacids at night for heartburn at least once a week? Yes____ no ____
Are you restless throughout the night, moving a lot? Yes____ no_____
Do your legs feel restless? Yes____ no ____if yes: during the day___when trying to sleep ____ during sleep___

What time do you go to bed on work days?_____ on your days off?_____
What time do you get out of bed on work days?_____ on your days off?_____
Do you sleep with anyone? Yes____ no_____ Is there a TV in your bedroom? Yes____ no ____

Do you wake up: refreshed? Yes____ No____
with a headache? Yes____ No____
with a dry mouth? Yes____ No____
How much caffeine do you consume in a day? 0-2 cups/day____ 3-5 c/d____ 6-10c/d____ >10c/d____
Have you ever felt paralyzed or as if you couldn't move when just falling asleep? Yes___ no____
Have you ever felt paralyzed or as if you couldn't move upon awakening? Yes____ no_____
Have you ever had vivid dreams when you felt like you were awake and just before falling asleep? Yes___no___
Have you ever had vivid dreams when you felt like you were awake after sleeping? Yes____ no_____

Have you ever experienced a sudden weakness of your head, jaw, and/or knees lasting seconds to minutes, brought on by surprise, laughing or other emotional stimulus? Yes____ no____
If yes, please explain _____
_____

Please circle any medical problems that you are having now:
Chills/Fatigue/Fever/Unexpected weight change/Congestion/Ear pain/Mouth sores/Nosebleeds/Sinus pressure/Trouble swallowing/Eye pain/Eye redness/Apnea/Choking/Shortness of breath/Chest pain/Leg swelling/Palpitations/Abdominal distention/Constipation/Diarrhea/Vomiting/Cold intolerance/Heat intolerance/Enuresis/Urinary frequency/Back pain/Joint swelling/Environmental Allergies/Immunocompromised/Headaches/Seizures/Tremors/Weakness/Adenopathy/ Bruise-bleed easily/Confusion/Decreased concentration/Dysphoric mood/Hallucinations/Hyperactive/Nervous-anxious/Suicidal ideas/Other:_____

Please check medical problems that you have:

__strokes __seizures/epilepsy __hypertension/high blood pressure __heart disease __high cholesterol ___high triglycerides ___asthma __emphysema __COPD __bronchitis __pneumonia ___thyroid disease __gastroesophageal reflux disease __ulcer ___anemia ___neuropathy ___ irritable bowel syndrome ___depression ___diabetes ___eczema

Please list any other medical problems you have: _____

_____

Please list all operations that you have had: _____

_____

_____

Have you had a tonsillectomy? Yes____ no____ when? _____
Have you had an adenoidectomy? Yes_____ no____ when? _____

Please list below all of your medications, dosage, and times that you take them.

_____

_____

_____

We are able to electronically access your medication information from your pharmacy (but please do enter your current medications above in order to avoid any discrepancies). **I authorize Dr. Sunseri to contact my pharmacy electronically and to access a list of my medications and submit my prescriptions electronically.**

_____

(Patient signature) (Date)

_____

(Pharmacy Name) (Pharmacy Phone#)

_____

(Pharmacy Address)

Please list below all medication allergies and any allergies you have to latex or tape. Please note what reaction you have with exposure to this as well.

_____

_____

Family Medical History

_____

_____

Please list any other information that your feel would be helpful for us to know regarding your sleep problem:

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Even if you do not do some of these things, try to evaluate how they would affect you. Use the following score to choose 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

Sitting and reading _____

Watching TV _____

Sitting in a public place _____
(theater or play)

Passenger in a car, 1 hour _____

Lying in resting in the afternoon _____

Sitting and talking with someone _____

Sitting quietly after lunch _____

In a car at a traffic light _____

Total

_____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME _____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				

week 1

week 2

West Penn Hospital

Directions to West Penn Hospital/Mellon Pavilion

4815 Liberty Ave, Suite 120 Pittsburgh, PA 15224

From the North:

Follow I-279 South to Route 28 North. Cross the 40th Street Bridge. Continue on 40th Street to Liberty Ave. Turn left onto Liberty Ave. West Penn Hospital is located at the intersection of Liberty and South Millvale Avenues.

From the Northeast:

Follow Route 28 South to the 40th Street Bridge. Continue on 40th Street to Liberty Ave. Turn left onto Liberty Ave. West Penn Hospital is located at the intersection of Liberty and South Millvale Avenues.

From the East:

Follow I-376 West to Wilkinsburg exit. Follow Ardmore Blvd. (Rte. 8) to Penn Ave. Turn left onto Fifth Ave. and follow to South Aiken Ave. Turn right onto South Aiken and follow to Baum Blvd. Stay straight onto Liberty Ave. West Penn Hospital is located at the intersection of Liberty and South Millvale Avenues.

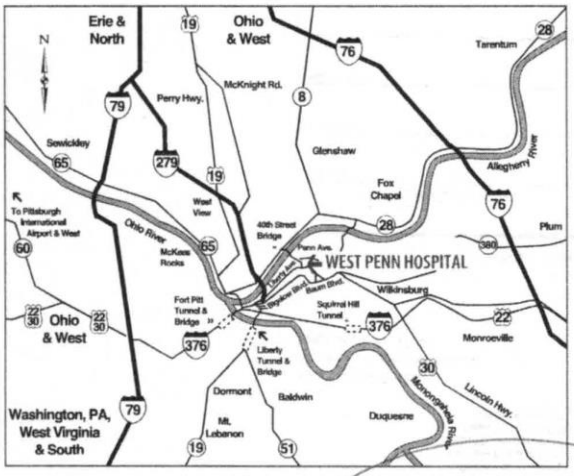
From the South:

Follow Route 51 North to West Liberty Ave. Turn right onto West Liberty Ave. and continue through the Liberty Tunnel and across the Liberty Bridge. Follow I-579 North to the Bigelow Blvd. exit (Rte. 380). Follow Bigelow Blvd. and take the Liberty Ave./Bloomfield exit, crossing the Bloomfield Bridge. Bear right at the end of bridge onto Liberty Ave. West Penn Hospital is located at the intersection of Liberty and South Millvale Avenues.

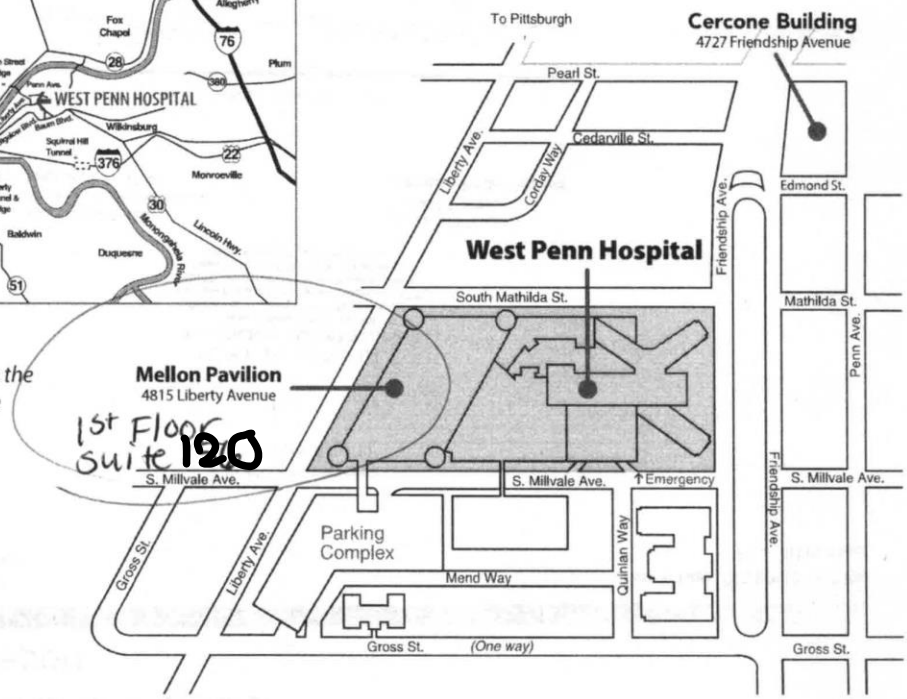
From the West and Pittsburgh International Airport:

Follow I-376 East through the Fort Pitt Tunnel and across the Fort Pitt Bridge. Take Liberty Ave. exit. Follow Liberty Ave. through Pittsburgh to Bloomfield. West Penn Hospital is located at the intersection of Liberty and South Millvale Avenues.

For the **Cercone Building**, *turn left onto South Millvale Ave. At the end of the street, turn right onto Friendship Ave. and loop around Friendship Park. The* **Cercone Building** *is located at the corner of Friendship Ave. and Edmond Street. Parking is available in the lot behind the building.*



For **Mellon Pavilion**, *park in the* Parking Complex *on Millvale Avenue and enter via the Skywalk on Level 2.*



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