Patient Demographics

(Please fill out both sides and all fields completely)

Patient Legal Name ______ Male / Female ______ Nickname

Date of Birth ______ Age (weeks, months, or years) ______ Social Security # ______ Phone#

Address ______ City ______ State ______ Zip Code

Primary Care Physician (PCP) ______ Phone# ______ Referring Physician ______ Phone#

Primary Insurance Information

Type of Insurance	Policy #	Group #
Policy Holder	Relationship to Patient	Social Security #
DOB of Policy Holder	Phone #	Co-Pay Amount

Secondary Insurance Information

Type of Insurance	Policy #	Group #
Policy Holder	Relationship to Patient	Social Security #
DOB of Policy Holder	Phone #	Co-Pay Amount

Parents / Legal Guardian(s) Information

Name ______ Relationship

DOB ______ Social Security #

Address if different from above

City ______ State ______ Zip Code

Home Phone# ______ Cell #

Name ______ Relationship

DOB ______ Social Security #

Address if different from above

City ______ State ______ Zip Code

Home Phone # ______ Cell #

Emergency Contact Other Than Parents / Guardian ______ Phone #

Is the patient your: Natural Child Adopted Child Foster Child Is in DHS Custody Other

REASON FOR VISIT

Please fill out both sides and all fields completely.

Has the patient seen anyone for this problem in the past? No Yes Who?____________________

Has the patient been in the hospital for this problem? No Yes Where?When?____________________

Has the patient had any tests for this problem?
EEG No Yes Where? When?____________________
MRI No Yes Where? When?____________________
CT No Yes Where? When?____________________
Labs No Yes Where? When?____________________

Is this problem related to any injury or accident? No Yes

Current Medications	Medication Allergies	Discontinued Meds Related to Problem

Family History	Self	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
Heart Disease							
High Blood Pressure							
Stroke							
Cancer							
Glaucoma							
Diabetes							
Epilepsy / Convulsions							
Bleeding Disorder							
Kidney Disease							
Thyroid Disease							
Mental Illness							
Osteoporosis							

Authorization: I consent to any medical diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physician. I hereby recognize that the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examinations that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulation in code 42 of Federal Regulations, part 2, if any; psychological services records, if any; social services records, if any; including communications made by me to a social worker or psychologist; records of Human Immunodeficiency Virus (HIV) testing including results, if any; records of treatment for Acquired Immune Deficiency Syndrome (AIDS), if any; and I authorize and request my insurance company to pay directly to Dr. Michel Alkhalil the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by my insurance.
I understand that if any employee, physician, or agent of the office of Dr. Michel Alkhalil sustains a percutaneous (through the skin) mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken before I signed.

____

Signature **Date**

Notice of Privacy Practices Acknowledgement with the Opportunity to Agree or Object

I Acknowledge:

A copy of the Privacy Notice for Dr. Michel Alkhalil and Dr. Peggy Rahal was made available to me at the office where I receive health care services.

The Notice of Privacy was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

A copy of the Notice of Privacy Practices was made available for me to keep.

I received the Notice of Privacy Practices before April 14, 2003, or no later than the first day I received health care services on or after April 14, 2003.

____

Signature of Patient or Guardian **Date:**

Patient Name____

Optional: Opportunity to Agree or Object

It is our policy to leave a message at your home regarding appointment reminders, prescription refills, testing arrangements, and non critical test results with additional instructions.

May we leave a message with a person or on an answering machine regarding the above? **Yes** **No**

I understand that the patient's test results are private and will not be released to anyone other than myself, unless I authorize it.

I authorize ____

(Relationship______________________________) to be given my / my child's test results.

I understand that the above instructions will be in force until I notify the office on any changes
(Initial here______________)

FOR OFFICE USE ONLY

If acknowledgement is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

____

Patients Name Date of Attempt to Obtain Acknowledgement

Reason acknowledgement was not obtained:______________________________________

____

Printed Name and Signature of Associate Date

Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Your age: (Yr) ________________ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale 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

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total	

Score:

0-10 Normal range
10-12 Borderline

Notice of Privacy Practices Summary for Dr. Michel Alkhalil and Dr. Peggy Rahal

This notice describes how medical information about you or your child may be used and disclosed. This notice also describes how you may obtain access to this information. Please review it carefully

Our Office Commitment to Respect Privacy

Dr. Michel Alkhalil is required to:

- Keep you and your child's record private.
- Let you know if we cannot do what you have asked us to do with your information
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and / or give your information as listed below and as the law permits, unless we have your permission.

Ways we might use or share information about you / or your child:

Treatment: For example; between the physicians and staff who need to discuss your / child's care.

Payment: Such as when we bill your insurance company for services provided to you or your child.

Operations: Such as when we work to make the quality of the care we provide better. When we give out information about different services we provide.

Other ways: Such as when we contact you as a reminder about an upcoming office visit, procedure or test.

You have the right to see and control how your information is used

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask in every case.
- Get and inspect a copy of your health record.
- Add information to your health record.
- Ask that your health information be sent to an alternate address or that you be called at an alternate phone number.
- Change your mind if you told us we could share your information for reasons other than those listed above.
- Obtain a list of the times we gave out your information.

As we serve our patients, it is possible that we may need to change what we do with your information. If in fact a change is made, you will be notified at your next office visit. Please feel free to contact us if you would like to see if any recent changes have been made.

Complaints

If you believe your privacy rights have been violated, you may complain to our office or the Department of Health and Human Services. You will not be mistreated for filing a complaint.

Contact Information

Troy Sleep Center
Attn: Privacy Officer
1500 W. Big Beaver Rd. Ste. 107
Troy, MI, 48084
Phone: (248) 689-1000
Fax: (248) 689-5711

FOR YOUR INFORMATION

YOUR INITIAL VISIT:
Most patients come to this office by referral from their pediatrician, family physician or other physician. The purpose of this visit is to obtain a detailed history, examination and possibly diagnostic testing necessary to establish care indicated.

APPOINTMENTS:
We ask that you call the office for an appointment, if you cannot make your office appointment, a 24 hour cancellation notice would be appreciated. If you need to cancel a sleep study it is required that you give a 48 hour notice.

In any busy M.D.'s day there are frequent unexpected occurrences that cause him/her to run behind schedule. We do respect your time and regret any delays. We are sure that you will understand if this does occur.

TELEPHONE:
Telephone conversations and consultation are the most common causes of the physician running behind schedule. We request that you use discretion in your phone calls for this reason. Please furnish the secretary with all the necessary information concerning the reason for your call and your pharmacy number if you anticipate a prescription might be required. We will return your call as soon as possible.

FEES:
Please be advised that in case of cancellation, we ask that you call our office no later than 24 hours prior to the procedure otherwise; there will be a ($100) charge fee for **late cancellations** and ($ 200) for **no show** on the night of the procedure.

INSURANCE:
Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company prior to any office or hospital procedure. **IT IS YOUR RESPONSIBILITY** to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred during your office visit or testing.

HMO ENROLLEES:
PLEASE BE ADVISED A REFERRAL IS REQUIRED FOR EACH VISIT. You must obtain a referral from you PRIMARY CARE PHYSICIAN before your visit with the specialist, not after. Your physician will not provide a referral to cover a visit you made without his or her prior approval.

REVISITS:
If our physician wants to see you for more visits or more services, your Primary Care Physician must agree to the additional care **IN ADVANCE.** If you need more care after the referral expires, your Primary Care Physician must approve a new referral. This is true even if you did not use all of the visits allowed in the first referral.