nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Patient Information

Name:	Date of Birth:
SSN:	Gender: ☐ Male ☐ Female
Home Address:	Employer:
Home Number:	Cell Number:
Work Number:	Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other
Referred by:	Email:
Primary Care Physician:	Preferred Pharmacy (Name & Phone Number):
Emergency Contact Name & Relationship:	Emergency Contact Number:
Legal Guardian Name & Relationship:	Legal Guardian Contact Number:

Insurance Information

Primary Insurance: _____ ID: _____ Group: _____

Secondary Insurance: _____ID: _____ Group: _____

IF THESE POLICIES ARE NOT IN YOUR NAME, PLEASE COMPLETE THE INFORMATION BELOW:

Insured Name: _____Date of Birth: _____ SSN: _____

Employer: _____ Contact Number: _____Relationship to you: _____

I agree to pay a cancellation fee of $50, if I do not keep my appointment or if I cancel with less than 24 hour notice. I request that my insurance company make payment directly to Nidraveda and/or its related entities for any services rendered. I agree that I am responsible for any applicable deductible and co-insurance amounts in accordance with the terms of my insurance policy. I am responsible for any non-covered charges. In the event that I receive payment from the insurance company, I will forward the full amount to Nidraveda and/or its related entities. I, the undersigned, authorize Nidraveda and/or its related entities access to all information regarding any medical history from all medical facilities in regards to my condition, and the release of such that may be requested by the insurance company for the purpose of processing claims. Medical records may be faxed to Nidraveda at 210.239.5060 or delivered to 4402 Vance Jackson Road, Suite 248, San Antonio, TX 78230.

Patient Signature: _____ Date: _____

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Patient Name: _____ Date: _____

Reason for Visit today (Primary Problem/ Symptom): _____

_____

Please check the symptoms you have and write the duration next to each one:

- ☐ Snoring
- ☐ Someone witnessed you stop breathing when asleep
- ☐ Choking/gasping for breath during sleep
- ☐ Sweating heavily at night
- ☐ Waking up with heartburn or reflux
- ☐ Waking up to urinate
- ☐ Difficulty falling asleep
- ☐ Awakening in middle of night
- ☐ Frequent breathing through the mouth
- ☐ Leg kicking
- ☐ Morning dry mouth
- ☐ Unrefreshing Sleep
- ☐ Teeth grinding during sleep
- ☐ Excessive sleepiness during the day
- ☐ Frequent awakenings at night (If so, how many times?) _____
- ☐ Waking up unrefreshed in the morning
- ☐ Seasonal Allergies
- ☐ Trouble falling and/or staying asleep
- ☐ Difficulty returning to sleep
- ☐ Nightmares
- ☐ Sleepwalking
- ☐ Feeling paralyzed when falling asleep or waking up
- ☐ Vivid dreams
- ☐ Feeling weak with certain emotions (i.e. happy, laughing)
- ☐ Feeling sleepy while driving
- ☐ Seizures
- ☐ Episodes of confusion
- ☐ Tongue and/or cheek biting
- ☐ Frequent falls
- ☐ Urinary and/or fecal incontinence
- ☐ Loss of consciousness
- ☐ Acting out dreams
- ☐ Screaming while asleep
- ☐ Head trauma
- ☐ Headaches (When?) _____Side? _____
- ☐ Light and/or sound sensitivity
- ☐ Nausea and/or vomiting
- ☐ Weakness (Where?) _____
- ☐ Tingling, numbness, and/or burning sensations

Anything make the symptoms better or worse? _____

<u>Procedural History:</u>

- ☐ EEG (When?) _____Where? _____
- ☐ Sleep Study (When?) _____Where? _____
- ☐ MSLT (When?) _____Where? _____
- ☐ Nerve Block/Botox (When?) _____Where? _____
- ☐ Other: _____

4402 Vance Jackson Road, Suite 248 | San Antonio, TX 78230
Voice: 210.686.5000 | Fax: 210.239.5060 | Web: www.nidraveda.com

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Patient Questionnaire

Patient Name: _____ Date: _____

Sleep Schedule & Hygiene:

Sleep time: _____ ☐ AM ☐ PM Time to fall asleep: _____ min Wake up time: _____ ☐ AM ☐ PM

Naps per week: _____ Average duration of nap: _____

Drink alcohol? ☐ Y ☐ N If so, how many per week? _____

Caffeine (sodas, coffee, tea, energy bars/drinks)? ☐ Y ☐ N If so, how many per week? _____

☐ Never ☐ Former ☐ Current Smoker: _____

If yes, how many packs per day? _____ How long? _____

Epworth Sleepiness Scale - How likely are you to FALL ASLEEP in the following situations? Please circle one number on each line.

	Never	Slight	Medium	High
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch without having consumed alcohol	☐ 0	☐ 1	☐ 2	☐ 3
Sitting, inactive in public place (such as, a theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3

Total Score: _____ / 24

Medical History:

- ☐ Allergic Rhinitis
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Acid Reflux
- ☐ Back Problems
- ☐ Cancer (Type:_____)
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Disease
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Head Trauma
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Hypertension
- ☐ Insomnia
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Narcolepsy
- ☐ Obstructive Sleep Apnea
- ☐ PTSD
- ☐ Restless Legs Syndrome
- ☐ Stroke
- ☐ TIA
- ☐ Vertigo
- ☐ Other:_____

4402 Vance Jackson Road, Suite 248 | San Antonio, TX 78230
Voice: 210.686.5000 | Fax: 210.239.5060 | Web: www.nidraveda.com

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Patient Name: _____ Date: _____

Surgical History:

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Bariatric Surgery (Specify): _____
- ☐ Brain Surgery (Specify): _____
- ☐ CABG
- ☐ Cardiac Catheterization (Stents?) _____
- ☐ Cataract Surgery
- ☐ Cholecystectomy
- ☐ C-Section
- ☐ Disc Fusion (Specify): _____
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Implant (Specify): _____
- ☐ Septoplasty
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Other: _____

Medication Allergies: _____

_____

Medications (with doses):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

4402 Vance Jackson Road, Suite 248 | San Antonio, TX 78230
Voice: 210.686.5000 | Fax: 210.239.5060 | Web: www.nidraveda.com

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Patient Name: _____ Date: _____

Family Medical History (include all relevant medical conditions):

Mother: _____ Daughter: _____

Father: _____ Cousin: _____

Brother: _____ Uncle/Aunt (maternal? paternal?): _____

Sister: _____ Grandchildren: _____

Son: _____ Grandparents (maternal? paternal?): _____

Review of Systems - Please mark any of the following symptoms you may be experiencing now or in the recent past (specify duration of symptoms, when possible):

General	☐ Fever ☐ Night Sweats ☐ Significant Weight Gain ☐ Significant Weight Loss
Eyes	☐ Dry Eyes ☐ Vision Changes ☐ Irritation ☐ Blurred Vision
ENMT	☐ Difficulty Hearing ☐ Ear Pain ☐ Frequent Nosebleeds ☐ Sinus Problems ☐ Snoring ☐ Dry Mouth ☐ Sore Throat ☐ Bleeding Gums
Cardiovascular	☐ Chest Pain ☐ Arm Pain on Exertion ☐ Shortness of Breath on walking ☐ Shortness of Breath lying down ☐ Palpitations ☐ Known Heart Murmur
Respiratory	☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing Blood ☐ Sleep Apnea
Gastrointestinal	☐ Abdominal Pain ☐ Vomiting ☐ Loss of Appetite ☐ Diarrhea ☐ Heartburn ☐ Vomiting Blood ☐ GERD
Genitourinary	☐ Incontinence ☐ Difficulty Urinating ☐ Increased Frequency ☐ Blood in Urine
Musculoskeletal	☐ Muscle Aches ☐ Muscle Weakness ☐ Joint Pain ☐ Back Pain ☐ Swelling in the extremities
Integumentary	☐ Abnormal Mole ☐ Jaundice ☐ Rash ☐ Lacerations ☐ Dry Skin
Neurologic	☐ Loss of Consciousness ☐ Weakness ☐ Numbness ☐ Seizures ☐ Dizziness ☐ Migraines ☐ Headaches ☐ Tremors
Psychiatric	☐ Depression ☐ Sleep Disturbances ☐ Alcohol Abuse ☐ Hallucinations ☐ Anxiety ☐ Suicidal Thoughts
Endocrine	☐ Fatigue ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Thirst ☐ Hair Loss
Hematologic	☐ Bruising ☐ Excessive Bleeding ☐ Swollen Glands
Allergic	☐ Runny Nose ☐ Sinus Pressure ☐ Itching ☐ Hives ☐ Frequent Sneezing

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Credit Card on File Policy

At Nidraveda, we require your credit card information to be stored for future payment for some of the following reasons:

- Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:
  - Co-insurance may be applied to the charges
  - Deductible has not been met for the current calendar year
  - Policy has terminated, or there is a gap in coverage.
  - Service may be deemed as not a payable benefit for your plan.
- You may have a copayment for medical services.
- You wish to set up a payment plan for a large balance on account.

Credit Card Authorization

By signing below, I authorize Nidraveda to keep a credit card on file for future payments and to charge all balances accrued on the patients listed below with the information saved. I further understand that if a payment is denied by the credit card on file, I will not be able to schedule any further appointments with Nidraveda until the balance has been paid in full and account may be sent to outside collection agency and patient may be discharged from the practice. I am aware that if any of my personal information has changed, I am responsible to notify Nidraveda of the change(s) to ensure they have the most current information to contact me or process payment accurately.

Signature of Patient or Responsible Party	Description of Responsible Party's Authority
Name of Patient or Responsible Party	Date

Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, and/or in the performance of Nidraveda and/or its related entities operations. The Notice of Privacy Practices also describes my rights and Nidraveda and/or its related entities duties with respect to my protected health information. The Notice of Privacy Practices is posted in Nidraveda lobby.

Nidraveda and/or its related entities reserve(s) the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Responsible Party	Description of Responsible Party's Authority
Name of Patient or Responsible Party	Date

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Nidraveda, P.A. Financial and Physician Office Policies

Thank you for choosing Nidraveda, P.A. and/or its related entities as your healthcare provider. We are committed to providing you with quality and affordable health care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and signing our financial and office policies form prior to seeing the physician. A copy will be provided to you upon request.

1. Insurance. It is your responsibility to understand with which insurance plans Nidraveda, P.A. participates. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Your health insurance policy is a contract between you and your insurance company, and it is your sole responsibility to understand its terms and conditions, this includes all prescribed medications.

2. Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you have a balance on your account we will ask for that payment as well. For you convenience, we accept cash, check, Visa, MasterCard, American Express, and Discover cards.

3. Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

4. Non-Covered Services. Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Nidraveda, P.A. and/or its related entities provides services that are medically necessary in the physician's professional opinion. Reduction of rejection of any claim by your insurance company does not relieve you of your obligation. In the event that your insurance company pays us for a claim that you had already paid and you are due a refund, we will be happy to expedite your refund or credit your account. You are ultimately responsible for all charges that are not covered under your health care policy.

5. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Please ensure that all personal and insurance information is correct at any time of each visit. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

6. Primary Care Physician Referral. Some insurance companies require a referral from your primary care physician before being seen by a Nidraveda physician. If your appointment requires a referral form your primary care physician, that referral will need to be on file with our office before the next appointment day. If you are seen without a referral form on file and the insurance company does not pay, you will be responsible for all charges.

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

7. Non-Payment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. If non-payment continues, legal action may be taken. Any legal fees will be your responsibility.

8. Letters / Form Completion. There is a minimum of $50.00 fee to complete any single document. Please note that we do our best to complete this paperwork for you in a timely and efficient manner. We require a minimum of 3 to 5 business days to complete this paperwork. There is a fee for copies of medical records not requested by another physician. Please ask the receptionist for an estimate if you need copies of your records. There is a $50.00 fee for any returned check. After one instance of a returned check, all further payment will be required to be in the form of credit card, cash or money order only.

9. Broken/Missed Appointments. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require **24 hour** notice of cancellation to avoid a ***$50 cancellation fee for a scheduled appointment***. It is your responsibility to remember your appointment. After 3 "no show" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician. If you are more than 15 minutes late for you appointment and have not called the office to inform us, we will reschedule your appointment.

10. Prescription Refills. All prescription refills **must** be called to your pharmacy. Your pharmacy can submit the refill request electronically, or they may fax the request to 210.239.5060. We DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication to ask your pharmacy for a refill. We require 2 business days to respond to a refill request. Please note that we do not process refill requests on weekends or holidays. The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescriptions refilled.

11. Triplicate Prescriptions. Due to Texas state laws, we have adopted the following policies regarding Triplicate prescriptions (Triplicate prescriptions are for Schedule II controlled substances): We will not mail Triplicate prescriptions. All expired Triplicate prescriptions that are not filled must be returned to our office. Triplicate prescriptions must be filled within 21 days. There is a $5.00 fee for each triplicate prescription that is not picked-up in a timely manner and a $25.00 fee for expired triplicate prescriptions (i.e. not picked-up in a timely manner).

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party	**Description of Responsible Party's Authority**
Name of Patient or Responsible Party	**Date**

nidraveda
hanul s. bhandari, md
fellowship trained & board certified, sleep medicine
board certified, neurology

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY PRIOR TO SIGNING THE ATTACHED PAGE. SIGNING THE PAGE ATTESTS YOUR UNDERSTANDING OF THIS NOTICE.

Nidraveda and/or its related entities may use health information about you for treatment, to obtain payment for treatment and/or services, for administrative purposes, and to evaluate the quality of care and services that you receive. Your health information is contained in a medical record that is the physical property of Nidraveda and/or its related entities.

Below is a summary of how Nidraveda and/or its related entities may use or disclose your health information:

For Treatment: Nidraveda and/or its related entities may use your health information to provide you with medical treatment or services. For example, information obtained by a healthcare provider, such as a physician, nurse, or other personnel providing health services to you, will record information in your record that is related to your treatment This information is necessary for healthcare providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to these actions. Nidraveda and/or its related entities may use your health information when referring you to other healthcare professionals and facilities

For Payment: Nidraveda and/or its related entities may use and disclose your health information to others for the purpose of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment and supplies used in the course of the treatment. Nidraveda may use your information to contact you about account balances.

For Healthcare Operations: Nidraveda and/or its related entities may use and disclose your health information for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to: evaluate the performance of our staff, assess the quality of care and outcomes in your cases and similar cases, learn how to improve our facilities and services, and determine how to continually improve the quality and effectiveness of the healthcare services we provide.

Required by Law: Nidraveda and/or its related entities may use and disclose information about you as required by law. For example, Nidraveda and/or its related entities may disclose information for the following purposes: judicial and administrative proceedings pursuant to legal authority, to report information related to victims of abuse, neglect, or domestic violence, to assist law enforcement officials in their law enforcement duties.

Appointment Reminder and Treatment /Service Calls: Nidraveda and/or its related entities may contact you to provide appointment reminders or information about treatment plans, medication or test results, other health-related benefits and services that may be of interest to you. When contacts are made via telephone, messages will be left on answering machines with Nidraveda name, the person calling, and the telephone number.

Notification: Nidraveda and/or its related entities may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Nidraveda health professionals, exercising their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relative to that person's involvement in your care or payment related to your care.

Business Associates: In some cases, Nidraveda and/or its related entities contract(s) with business associates to provide services on its behalf. An example of this includes arrangements with associates of Nidraveda to provide collection services. Nidraveda and/or its related entities may disclose your health information to such a business associate so that they can perform their respective job functions. To protect your health information, however, Nidraveda and/or its related entities require(s) that the business associate to safeguard your information.

Public Health: Your information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Government Agencies: Nidraveda and/or its related entities may disclose to the Food and Drug Administration (FDA) health information relative to adverse events with respect to products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require disclosure of your health information.

Worker's Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Worker's Compensation.

Other Uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent that Nidraveda and/or its related entities has/have taken action in reliance on such.

Your Health Information Rights: You have the right to request a restriction on certain uses and disclosure of your information (however, Nidraveda and/or its related entities is/are not required to agree to a requested restriction), obtain a paper copy of this notice of information practices upon request, inspect and obtain a copy of your health record, request that your health record be amended, request communications of your health information by alternative means or at alternative locations, and receive an accounting of disclosure made to your health information.

Complaints: You may complain to Nidraveda and to the Department of Health and Human Services if you believe your privacy lights have been violated. You will not be retaliated against for filing a complaint.

Obligations of Nidraveda: Nidraveda and/or its related entities is/are required to: Maintain the privacy of protected health information, provide you with this notice of its legal duties and privacy practices with respect to your health information, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction on how your Information is used or disclosed, and accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations

Nidraveda reserves the right to change the information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you in our facility.

Contact Information: If you have any questions or complaints, please contact Dev Buttar (Nidraveda Compliance Officer) via mail at 4402 Vance Jackson Road, Suite 248, San Antonio, TX 78230 or phone at 210.686.5000.