Manoher L. Gurru M.D.

601 E. 2nd Street **Odessa, TX 79761**

702 Andrews Hwy **Midland, TX 79701.**

Phone :(432) 580-9700 **Fax: (432) 580-9703**

www.brainanc.com

POLYSOMNOGRAM INSTRUCTIONS

You are scheduled for an all night sleep study. **It is important that you arrive at your scheduled time** as there may be other patient(s) scheduled on the same night of your study.

IMPORTANT NOTICE

There are two studies involved for a sleep evaluation. The first study or night is for diagnostic evaluation of a broad spectrum of sleep disorders. This first night evaluation provides valuable information concerning sleep architecture, REM related sleep disorders and severity of respiratory disorders (i.e. obstructive sleep apnea). If the diagnostic night reveals a necessity for treatment of a respiratory disorder (i.e. obstructive sleep apnea), then a second night will be required. This second night study will allow adequate time for treatment adjustments, evaluation of REM sleep, and provide data that can be referenced and compared to the first night study. Furthermore, in order to have the best possible results, we strongly recommend that you bathe prior to arriving at Advanced Sleep Center for your test. It is imperative that your scalp be scrubbed and free of all oils, gels and hair products, so that the electrodes can function properly.

1. Bathe and wash your hair twice with shampoo before your study in order to remove all oils from your scalp.
2. Do not use the following products on your hair:
   a. Hair spray, hair conditioner, hair oil, hair gel and any type of mousse.

PLEASE BRING

* Your bedtime clothes and change of clothes for the next day.
* Your toiletries (i.e., toothpaste, toothbrush, etc.)
* Your medicines as prescribed by your doctor. The Advanced Neuroscience Sleep & Seizure Clinic cannot provide you with medicines. Certain medicines are not to be taken during the study. With the consent of your physician, the medicine(s) may be withheld.
* A comfortable pillow and personal blanket (if you forget, we will provide these for you).
* Books or other reading material if you normally read before sleep.
* You may bring a snack.

PROCEDURE

The technician will ask you to change into your bedtime clothes and fill out a bedtime questionnaire. S/He will then mark and measure your head so as to apply the proper placements of the EEG (brain wave) electrodes. None of the monitoring devices will hurt. None of the devices will cause or induce pain.

WHAT IS A POLYSOMNOGRAM?

A polysomnogram is a procedure which measures bodily functions during sleep.
Each study will vary depending on each individual case, and some of the measurements taken may include the following:

a. Brain Waves (Electrodes placed on the scalp)
b. Heart Beat (Electrodes placed on the chest)
c. Eye Movement (Electrodes placed above and below the eyes)
d. Muscle Tension (Electrodes placed on the chin)
e. Leg Movement (Electrodes placed on the lower legs)
f. Breathing /Airflow (Sensor placed underneath the nose)
g. Chest and Abdominal Movements (Sensor placed around the chest and abdomen)
h. Blood Oxygen Levels (Sensor attached to a finger)

Our sleep rooms are setup to resemble comfortable hotel or bed rooms. The sleep center rooms have a private, relaxed environment and are not like hospital observation rooms. When you arrive to the Sleep Center a technician

will greet you and go over your sleep questionnaires. The technician will then ask you too change into your bedtime clothes and fill out a bedtime questionnaire. The technician will then begin the hook-up process. The entire hook-up procedure takes approximately 45-60 minutes. After the hook-up procedure is completed you are welcome to watch television (basic cable) or read a book until you feel tired or ready for sleep. Access to the office is limited. We typically start the sleep study between 10-11:30 pm. During the night if you need to use the restroom, just call out to the technician who will hear you through an open intercom connection. The technician will come in and disconnect a lead wire and you are free to use the restroom on your own. You are also allowed to sleep in any position during the night, although we would like to see some time on you back. If you have a medical condition that prevents you from sleeping on your back, please let the technician on duty know. Do not be afraid to sleep in any position. The monitoring devices are very sturdy. If a monitoring device gets pulled off, the technician will fix it. In the morning, the technician will remove all of the monitoring devices. This process takes about 15-20 minutes. Afterwards, you are free to wash up. The study usually ends between 5:30-6:30 am.
Please note: You are to eat dinner prior to coming to the Advanced Sleep Center. If you require special assistance in getting in and out of bed, you must bring an aide to be responsible for this care. Please take a shower and wash your hair prior to coming to the Advanced Sleep Center. Removal of all make-up, perfume/cologne prior to coming to the Advanced Sleep Center is recommended. Please leave all valuables at home when scheduled for your sleep study.

DO NOT CONSUME ANY CAFFEINATED OR ALCOHOLIC BEVERAGES AFTER 12:00PM ON THE DAY OF YOUR STUDY. THANK YOU.

NOTE: PLEASE DO NOT DISCONTINUE ANY PRESCRIBED MEDICATIONS WITHOUT FIRST CONSULTING A PHYSICIAN.

IF FOR SOME REASON, YOU CANNOT KEEP THIS APPOINTMENT, YOU MUST NOTIFY US WITHIN 72 HOURS. OTHERWISE YOU MAY BE ASSESSED A $250.00 CANCELLATION FEE.

☐ **INSTRUCTIONS FOR DIAGNOSTIC STUDIES**
During your sleep study, you will undergo a comprehensive sleep evaluation. This test will examine all sleep patterns and sleep disorders. The sleep test will also allow the sleep physician to make a proper evaluation and recommendation for treatment. You will be allowed to sleep in any position; however we would like to see some time on your back (unless you have a medical condition that would make it difficult to sleep on your back). If during the middle of the night, the technician has still not seen you on your back s/he will either roll you on your back or wake you up and ask you to sleep on your back. **Do not take any naps the day of your study. Do not drink any caffeinated beverages after 12:00 pm.**

☐ **INSTRUCTIONS FOR ALL NIGHT TREATMENT STUDIES (CPAP/ BI-LEVEL)**
During your sleep study, you will undergo a comprehensive sleep study, which will entail treatment with either CPAP (Continuous Positive Airway Pressure) or BI-LEVEL (dual-level Positive Airway Pressure). These treatment types are essentially room air that is used to splint the airway to prevent snoring and apneas. The room air is delivered via mask that will be worn under or over your nose. There are many different mask types to choose from and a technician will go over these with you. In this portion of the night you are also allowed to sleep in any position, however we would also like to see some time on your back. If during the middle of the night the technician has still not seen you on your back, s/he will either roll you on your back or wake you up and ask you to sleep on your back. **Do not take any naps the day of your study. Do not drink any caffeinated beverages after 12:00 pm.**

IMPORTANT NOTICE

Test Results will be completed in 5-7 business days. There is **no** need to follow up with a physician after the results are completed. If you have been instructed by your physician to setup a follow up appointment or if you have additional questions or concerns and would like to setup a follow up appointment, then please feel free to do so.

CPAP/ BI-LEVEL units to be setup in your home will occur 7 to 10 business days after your sleep study. A Home Health Company will contact you by phone to arrange a time to get the CPAP/ BI-LEVEL equipment setup. This company will go over mask types, mask fittings, equipment maintenance, and equipment education. If you have any questions please feel free to discuss them with the representative. CPAP/ BI-LEVEL therapies take time for the body to get adjusted to. **DO NOT BE DISCOURAGED!** Give your body a chance to adjust to the treatment, and this may take a week up to 3 months. If you have any problems with the machine or mask please contact the Home Health Company and a representative will be there to assist you.

ADVANCED SLEEP CENTER

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Patient's Name:____________________________________Date of Birth:_____________ Date:_____________________

Age: ___ Height: ___ Weight: ___ Neck Circumference: _____In. Marital Status: ________________________

Living Arrangements: _______________________ Referring Physician: ____

Why Are You Here? (Reason for the visit/study in your own words): ____

____

Sleep Schedule:

1. What time on weekdays do you usually go to bed________________ PM/AM Wake up ________PM/AM
2. What time are you usual working hours, if applicable. Begin ________PM/AM End _________PM/AM
3. What time on weekends do you usually go to bed ________________PM/AM Wake up_________PM/AM
4. On average, how long do you actually sleep at night? Weekdays_____Hours Weekends______Hours
5. Do you fell that you get too much or too little sleep at night.. Too Much/Too Little?
6. Do you need or rely on an alarm clock to wake you up…………………………………………………………..……….. Yes/No?
7. How long does it take you to get out of bed after waking up? ________Minutes
8. Do you toss and turn a lot at bedtime trying to find a comfortable position………….. Yes/No?
9. Is your bed, your pillows, and bedroom temperature comfortable…………………………………………………….. Yes/No?
10. Does your bed partner snore habitually…………………………………………………………………………….……… Yes/No?

Night Time Symptoms: (circle answer**)**

11. How long does it normally take you to fall asleep at night after turning off the light? ________Minutes
12. Do you have trouble falling sleep? …...…………………………............ ……………………………………………Yes/No?
13. Do you wake up during night? How many times __________ Reason: ____
14. Do your feet and legs have discomfort with irresistible urge to move them…...…………………………............ Yes/No?
15. Do you have crawling sensations in your legs while falling asleep…………………………………………………... Yes/No?
16. Do you kick in bed at night? …...…………………………............ …………………………………………………. Yes/No?
17. Do you feel the need to move your legs at night? …...…………………………... Yes/No?
18. Do you have a sudden body jerk when falling asleep……………………………………………………………………….. Yes/No?
19. Do you awake with muscle aches? …...…………………………... Yes/No?
20. Do you have vivid dreams as you are falling asleep……………………………………………………………… Yes/No?
21. Do you wake up unable to go back to sleep……………………………………………………………………………. Yes/No?
22. Is your sleep disturbed by a medical problem………………Yes/No? Describe: ______________________________
23. Do you have thoughts that prevent sleep…………………………………………………..……………….………. Yes/No?
24. Do you have trouble getting to sleep at night…………………………………………………..…………,……….. Yes/No?
25. Do you awaken repeatedly for no clear reason…………………………………………………………………..…… Yes/No?
26. Do you awaken at night to use the bathroom…………………………………………………………………...........…. Yes/No?
27. Are you ever awakened with coughing, shortness of breath, or gasping……………………………………………..... Yes/No?
28. Do you have twitching movements in your legs during the night……………………………………..…………… Yes/No?
29. Do you awaken with racing thoughts, sadness, or anxiety………………………………………………..……... Yes/No?
30. Have other people told you that you have restless sleep.. Yes/No?
31. Do you wake up and hear yourself snoring or have someone told you that you snore………….. …….…….…. Yes/No?
32. Do you wake up with headaches during the night…………………………………………………………..………. Yes/No?

33. Do you wake up a sour or bitter taste in your mouth (Heartburn)…………………………………………...……….. Yes/No?

34. Is it difficult for you to awaken and get out of bed after sleeping……………………………………………...…… Yes/No?

35. Do you have frequent nightmares…………………………………………………………………………….……… Yes/No?

36. Do you wake up during the night confused………………………………………………………………….... Yes/No?

37. Do you act out your dreams……………………………………………………………………………….….… Yes/No?

38. Do you injure your bed partner or yourself…………………………………………………………….…….. Yes/No?

39. Do you have convulsions or seizures during your sleep……………………………………………………... Yes/No?

40. Do you grind your teeth…………………………………………………………………………………….... Yes/No?

41. Do you wake up but unable to move your body?.......................……………………………………….………. Yes/No?

42. Do you have unusual behavior at night? …………………………………....…………………………........... Yes/No?

43. Have you been gaining weight? …..…………………………... Yes/No?

44. Have you ever felt heart pounding or beating irregularly during the night…..……………………………............. Yes/No?

AFTER AWAKENING:

45. Upon waking up, do you feel your sleep was refreshening enough... Yes/No?

46. How would you rate your energy level? _____fully energized ______________feel fine_____________not energized

47. Do you have any of the following? __________morning headaches __ ______dry mouth ___________ nasal congestion

48. Do you drink coffee or tea in the A.M…………………………...Yes/No? (If so, how much? ___________cups in A.M.

49. Do you feel sleepy in the morning……………..Yes/No? After Lunch………Yes/No? After Dinner………..Yes/No?

50. In the morning, when you wake up, do you:

	Yes / No		Yes / No
a. Need an alarm clock to wake you up?		b. Immediately feel refreshed?	
c. Need coffee or a shower to feel alert?		d. Often have a dry mouth	
e. Often have a sore throat?			

DAYTIME SYMPTOMS:

51. Do you feel tired throughout most of the day………………………………………………………………………… Yes/No?

52. Do you feel rested or refreshed after a nap……………………………………………………………………………. Yes/No?

53. Do you find yourself falling asleep when you don't mean to……... Yes/No? How often? _______

54. Do you take naps during the day………. No need / I want to but can't Number of times a week_____How Long_____

55. Have you fallen asleep at the wheel? …..……………………………... Yes/No?

56. During day do you feel dazed as if in a fog?

57. Do you often feel that you must feel your day with activity? …..………………………………............................. Yes/No?

58. Have you noticed, or been told about, any changes in your personality recently, such as:

	Yes / No		Yes / No
a) Irritability		e) Loss of Concentration	
b) Increased temper		f) Spaced out Feeling	
c) Anxiety		g) Decreased Job Performance	
d) Depression		h) Poor Memory	

59. Have you ever had the following kinds of weakness develop suddenly during an emotional situation?
(For example, when laughing, if angry, if in an exciting situation, etc.)? (check one on each line):

	NEVER	1-5 TIMES IN YOUR LIFE	MONTHLY	WEEKLY	DAILY
Knees Buckling					
Mouth Opening					
Head Nodding					
Falling Down					

60. Do you know, or others tell you that you;

	AGE STARTED	LAST OCCURRED	FREQUENCY	TREATMENT
Talk while apparently sleep?				
Walk while apparently sleep?				
Grit teeth while apparently sleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

Social History:

61. Have you ever smoked cigarettes, cigars, or pipes……………………………………………………………………… Yes/No?

If yes, which one(s): ______Cigarettes _______Cigars _______Pipes _______Chewing Tobacco

How much? __________Pack(s)/ day _______Total number of years smoking (approximately)

Have you quit? ________Yes ____No If yes, when? _______ (year)

62. Do you drink any form of alcohol (example: beer, wine, etc.)………………………………………………………... Yes/No?

If yes, _______Occasionally ______Socially _______Daily (please state how much: _________________)

Have you ever been told that you may have an alcohol problem by your family, friends, or doctor……………… Yes/No?

63. Do you currently live at home? ____Yes ____No other: ______Nursing Home ________Assisted Living

64. Have you ever been exposed to possible environmental toxic inhalants…………………………………………….. Yes/No?

If yes, please explain: ____

Family History: (alive/dead, cause of death, healthy/sick, disease/illnesses)

Father: ____

Mother: ____

Siblings: ____

Grandparents: ____

Does any one in family have sleep Apnea? ____

Sinus History: (Check all that apply)

- ☐ Nasal Congestion
- ☐ Nasal Blockage
- ☐ Nasal Discharge
- ☐ Sneezing
- ☐ Dry Nose
- ☐ Dry Mouth
- ☐ Sore Throat
- ☐ Nasal Discharge with Bleeding
- ☐ Nasal Discharge without Bleeding
- ☐ Allergies causing nasal symptoms

Have you had any of the following?

- ☐ Tonsillectomy
- ☐ Adenoidectomy
- ☐ Nasal or sinus surgery
- ☐ Vocal cord surgery
- ☐ Other surgery

Current Medications:

____

____

____

Health History: (Check all those that you currently have or have had in the past)

- ☐ Sleep Apnea
- ☐ Sinusitis
- ☐ Bloody Sputum
- ☐ Arthritis
- ☐ Heart Failure
- ☐ Hiatal Hernia
- ☐ Kidney Disease
- ☐ Depression
- ☐ Seizures
- ☐ Insomnia
- ☐ Bronchitis
- ☐ Pleurisy
- ☐ Heart Attack
- ☐ Peptic Ulcer
- ☐ Accident/Trauma
- ☐ Neck Pain
- ☐ Schizophrenia
- ☐ Stroke/ TIA
- ☐ Hay Fever
- ☐ Chronic Cough
- ☐ Lung Cancer
- ☐ High Blood Pressure
- ☐ Brain Disease
- ☐ Memory Loss
- ☐ Mental Disorder
- ☐ Back Pain
- ☐ Asthma
- ☐ Pneumonia
- ☐ Fibromyalgia
- ☐ Heart Bypass Surgery
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Bipolar
- ☐ Cancer
- ☐ Acid Reflux
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Gout
- ☐ Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Liver Disease

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EPWORTH SLEEPING SCALE

Do you feel very sleepy or fall asleep during these situations?

0 = no chance of dozing, **1**= slight chance, **2**= moderate chance, **3**= high chance.

Sitting and Reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting inactive in a public place	**0**	**1**	**2**	**3**
As a passenger in a car for an hour with out a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic or at a red light	**0**	**1**	**2**	**3**

TOTAL………………

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME: ____________________________ FIRST NAME: _____________________________ MIDDLE: _______________

ADDRESS:_______________________________ CITY:_________________________ ST:____________ ZIP:________________

SEX: ☐ MALE ☐ FEMALE DOB:_____________ AGE:__________ SS#: ______________________

HOME #: ____________________ CELL #:_____________________________________ WORK #: ___________________________

EMPLOYER INFORMATION:

MARTIAL STATUS ☐ MARRIED ☐ SINGLE NAME: ____________________

☐ DIVORCED ☐ WIDOWED CITY, ST & ZIP: ____________________

☐ MINOR PHONE: ____________________

REFERRING PHYSICIAN___________________________________

PATIENT INSURANCE INFORMATION:

INSURANCE NAME________________________________ POLICY #: _______________________ GROUP #: _______________

(IF different from the patient)

CARD HOLDER'S NAME_____________________________ DOB:___________________ SS#_______________________________

SECONDARY INSURANCE INFORMATION:

INSURANCE NAME_____________________________________ POLICY #: __________________ GROUP #: ____________________

(IF different from the patient)

CARD HOLDER'S NAME_____________________________ DOB:___________________ SS#_______________________________

PHARMACY INFORMATION:

PHARMACY NAME: _____________________________________ PHONE: _________________________ CITY: ___________________

WORKERS' COMPENSATION:

WORK RELATED? ☐ YES ☐ NO DATE OF INJURY: _____________________

ADJUSTER NAME: _____________________________________ PHONE #_________________________

LIABILITY: **(Please complete this section if your illness /injury is the result of an accident, auto or otherwise-BUT not work Related)**

INSURANCE NAME:________________________ DATE OF ACCIDENT:____________________ POLICY #:___________________

CLAIMS ADJUSTER NAME:_______________ PHONE #: _____________________________ CLAIM #: _______________________

GUARANTOR -RESPONSIBLE PARTY INFORMATION:

FIRST NAME: ____________________________ MIDDLE: _____________ LAST NAME: __________________________________

SS:_________________________________

RELATIONSHIP:_______________________ DOB_____________ SEX: ☐ MALE ☐ FEMALE

ADDRESS:_______________________________ CITY:_________________________ ST:_____________ ZIP:________________

EMPLOYER: ____ PHONE #: ___________________________________

ADDRESS:______________________________ CITY:_________________________ ST:_____________ ZIP:_____________

EMERGENCY CONTACT (If different from above):

NAME: ____ RELATIONSHIP:____

HOME #: _____________________ CELL #:____________________________________ WORK #: ____________________________

I, the undersigned, a patient in this office, herby authorize the treating doctor, to administer such treatment as necessary. I agree to pay all charges for me and members of my family, shown by statement ,promptly upon presentation here of, unless credit arrangements have been agreed upon, prior to care. I also herby authorize payment of insurance benefits otherwise payable to me directly, to the doctor. I authorize release of any information concerning my(or my child's) health care, advice provided for the purpose of evaluation claims for insurance benefits.

Signature (Patient or Parent of Minor): ___________________________________ **Date:** ________________

As a parent of legal guardian, I authorize the treating doctor and whomever he designates as his assistant to administer treatment to this minor child. I am financially responsible for the minor child.WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.

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NO SHOW ---- CANCELLATION --- LATE FEE POLICY

There is a **$250.00** charge for appointments that are not kept or cancelled with 72-hour notice before your scheduled sleep study appointment. If you show up late for your Scheduled appointment, you may be turned away and be charged as well. Please contact us at (432)580-9700 should the need arise.

Your health insurance will **NOT** pay for this fee. You will be the responsible party.

This policy is instituted as part of our sleep center's goal to provide superior care for our valued patients. We have many patients in need of sleep testing and a highly qualified sleep technologist is scheduled in advance for your specified sleep testing needs. *It is essential that you let us know immediately if you are unable to keep your appointment.*

Your signature below acknowledges that you have received notice of this policy and will be responsible for canceling in advance as well as any charges resulting from non-compliance to this policy.

_______________________________ ____________________

Patient Date

By: ASC Management

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Consent to Treat

I, ________________________________, the patient or legal guardian of patient, do consent to the testing and treatment associated with Polysomnography, including CPAP and/or Bi-level as prescribed by my physician. I hereby authorize Advanced Sleep Center to provide medical diagnostic care reasonable by the standards set forth by the American Board of Sleep Medicine. I have had the procedure explained to me in detail and given the opportunity to ask questions.

____
Signature of Patient or Legal Guardian

____
Printed Name of Patient or Legal Guardian

____
Date

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Release for Photograph and Digital Video Recording

I, ___________________________the undersigned, consent to and authorize photography, digital video recording and/or audio recording to be done during the testing procedure by the employees of Advanced Neuroscience Sleep & Seizure Clinic. I understand that the digital recording is acceptable in Texas Courts under the Texas Rules of Evidence.

Anonymity of the patient(s) will be insured.

The contents of this release was read and understood by the undersigned patient.

______________________________________ ______________________________________
Signature of the Patient Date and Time

______________________________________ ______________________________________
Signature of Witness Date and Time

______________________________________ ______________________________________
Signature of a Guardian (for minors) Date and Time

Guardian's Relationship to Patient: ________________________

Guardians Signature is necessary when a subject is a minor or otherwise unable to sign on their own behalf:

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Bed Partner Questionnaire

(To be completed by pt's bed partner)

Patient Name: ____ Date: ________________

Your Name: ____ Relationship: __________

I have observed this person sleep (circle one): Never Once Twice Often Every Night

Check any of the following that you have observed this person doing while asleep. **Check** those that you consider severe problems.

__Light Snorer
__Moderate Snorer
__Loud Snorer
__Twitching or Kicking of Legs
__Choking
__Sitting up in bed Not Awake
__Head Rocking or Banging
__Biting Tongue
__Crying out
__Becoming very rigid and shaking
__Apparently sleeping even if he/she says otherwise
__Occasional Loud Snorts
__Grinding Teeth
__Pauses in Breathing
__Sleep Talking
__Bed-wetting
__Awakening with Pain
__Getting out of bed Not Awake

Other____

If this person snores, what makes it worse?
__Sleeping on his/her back
__Sleeping on his/her side
__Fatigue
__Alcohol

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night, and whether it occurs every night.

____
____
____
____
____

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes/No? If yes, please explain:

____
____
____
____

Does this person use sleeping pills? Yes/No? What kind? ____
How often?____
Does this person drink alcohol? Yes/No?
Please estimate the per (weeknight/weekend) use of: ___/___12 oz. Bottle/can/tap beer. ___/___6-8 oz. Glasses of wine
___/___ 1-1/2 oz. bottle/cap/tap liquor.
Please estimate how much alcohol this person consumes in the 3 hours before bed:

____

If this person uses recreational drugs, please describe both the types and frequency of usage:

____

Advanced Neuroscience Clinic, P.A.

IMPORTANT PATIENT POLICIES

Financial Policies: (Please initial next to each policy)

_____ Payment is due at the time of service unless other arrangements have been made in advance.

_____ As a courtesy to our patients, we participate with many of the heath plans. However, you are ultimately responsible for payment of services. Please be aware of your specific plan benefits. If your insurance carrier fails to pay in a timely manner, you will be responsible to pay.

_____ Copays/Deductibles/Past due balances are collected prior to each visit. These will be collected in full prior to seeing the physician. Patients will be rescheduled if balances are not paid in full or prior arrangements are not made for a payment plan.

_____ There will be a $25 charge on all returned checks. All visits thereafter will be on a cash basis only, payable prior to being seen. Returned checks not paid within 10 days will be referred to the District/County Clerk for collection.

Policy Regarding Completion of Forms and Medical Records:

_____ All forms including Disability, FMLA, Drug Assistance, etc. are only accepted during your regular appointment, and completed on the 3rd Friday of the month. There is a $35 charge due prior to completion of these forms. Your insurance company does not cover this fee.

_____ A fee of $25 will apply to medical records requests for the first twenty pages and an additional $0.50 per page thereafter.

Appointment Policies:

_____ As with any medical office, delays may occur due to unforeseen emergency situations. Please be patient with us as we work through these times. The same care and dedication will be given to you during your appointment. We will keep you informed of the anticipated delay time, however please feel free to reschedule your appointment if necessary.

_____ If you are not able to make your scheduled appointment, please provide our office with a 24 hour cancellation notice. Appointments not cancelled within 24 hours will be considered a “No Show”. Patients who “No Show” for a second time will be billed a $25 “No Show” fee that must be paid prior to being re-scheduled. The 3rd “No Show” will result in the patient being discharged from the clinic.

_____ Please allow 3-5 business days for all Lab and Radiology results, including CT, MRI, MRA, etc. Only patients with abnormal results will be routinely notified. Please feel free to contact our office after this time.

_____ Please bring all medications in their original bottles to each visit. Please notify us during your appointment if refills are needed. All other refill requests are handled within 48 hours of receipt by this office. Please keep in mind that we are not open on Saturday and Sunday.

_____ Dr. Gurru is a specialist and does not treat problems not associated with Neurology. Please maintain a primary care physician at all times to evaluate and treat these issues.

_____ Dr. Gurru is an investor in Basin Health Care Hospital and Odessa Regional Medical Center. At times, he refers patients to these hospitals in connection with their care and treatment.

Date: ___________

Patient/Guardian Name: ______________________________ Signature: ___________________________________

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 IT CAREFULLY.

This practice understands that medical information about you and your health is personal. We are committed to protecting this information. This practice will create a record of care and services you receive as a basis for planning your care and treatment, for communicating with the many healthcare professionals involved in your care, to obtain payment for services provided, as a source of information for public health officials, and to provide you with quality care while complying with certain legal requirements.

By law, this office is required to provide you with our Notice of Privacy Practices. If you should have any questions about this Notice or to submit requests pursuant to this Notice, please contact the Practice Manager at (432) 570-9991. A copy of this Notice is available upon request.

Methods Medical Information may be Used and Disclosed

The following information describes different ways this office may use and disclose your medical information. Although examples are given, it is impossible to list every use or disclosure.

For Treatment We are permitted to use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management with other physicians of facilities. For example, the physicians in this practice are specialists. When we provide treatment, we may request information from your referring physician as well as provide information about your diagnosis and treatment so that he may appropriately treat you for other medical conditions.

For Payment We may use and disclose information about you to bill and collect payment for services provided to you from your insurance company, Medicare, you, or other payer. For example, we may need to disclose information about you to a healthy plan in order for the health play to pay for your physician for the services you received. We may also need to inform your health plan about a treatment of procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover these services.

For Health Care Operations We are permitted to use and disclose medical information about you in order to efficiently operate our office and ensure all patients receive quality care. For example, your medical records or health information may be used to evaluate health care services, and the quality of your treatment. In addition, medical and billing records are audited to ensure we maintain our compliance with federal and state regulations.

Appointment Reminders and Other Health Related Benefits We may use and disclose medical information about you as a reminder of an upcoming appointment, or to inform you of treatment alternatives or other health related benefits. For example, we may provide a reminder of your next appointment by telephone, voicemail/answering machine, or written notice.

Research of Other Qualified Personnel We may use and disclose medical information about you for research or for management audit, financial audit, or program evaluation. You will not be directly or indirectly identified in any report of the research, audit, or evaluation. Your identity will not be disclosed in any manner.

Organ and Tissue Transplants If you have formally indicated your desire to be an organ donor or recipient, we may release medical information to organizations who handle procurement of organ, eye, or tissue transplantation.

Coroners, Medical Examiners, and Funeral Directors We are permitted to release information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release information to funeral directors in order for the director to carry out his duties.

Military, Veterans, and National Security If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose your medical information for specialized governmental functions, authorized national security and intelligence activities, and for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

As Required by Law We will disclose medical information about you when required by federal or Texas law regulations.

Public Health Risks and Health Oversight We may disclose your medical information for public health activities which may include the prevention or control of disease, injury or disability, to report births and deaths, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your information to report reactions to medications or problems with products, or to notify individuals or recalls of product they may be using.

Medical information about you may be disclosed to health oversight agencies for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. They may include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor government programs, eligibility or compliance, and to enforce civil rights and criminal laws.

Abuse or Neglect We will disclose medical information in order to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report the abuse or neglect of elders or the disabled.

Worker's Compensation Medical information about you may be disclosed to provide benefits to you for work-related injuries or illnesses.

Lawsuits and Disputes If you are involved in certain lawsuits or administrative disputes, we are permitted to disclose medical information about you in response to a court order or administrative order.

Law Enforcement If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided the information:

- Is in response to a court order, warrant, or subpoena;
- Pertains to a victim or crime, whether living or deceased, and we are unable to obtain the person's agreement;
- Is released because a crime has occurred on these premises;
- Is released to locate a fugitive, missing person, or suspect.

We may also release medical information about you when necessary to prevent a serious threat to your health and safety, including mental and emotional injury to you, or the health and safety of the public or another person.

Inmates If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional facility or law enforcement official. This release is permitted to allow the institution to provide you the medical treatment, to protect your health or the health and safety of others, or for the safety or security of the correctional facility.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

The U.S. Department of Health and Human Services created regulations intended to protect your rights as a patient as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following are rights regarding your medical information which this office collects and maintains. We will not retaliate against a patient who exercises their rights under the HIPAA.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information this office uses or discloses about your treatment, payment, health care operations. You also have the right to request a limit on the medical information disclosed to someone who is not involved in your care or the payment for your care. *We are not required to agree to your request*. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions you must make your request in writing to the Practice Manager. Include the following in your request: (1) what information you want to limit; (2) what kind of restriction you are requesting; (3) to whom the limits apply. For example, you may request we limit disclosure to your spouse, family members or other relatives, or close personal friends who may or may not be involved in your care.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask to be contacted only at work or by mail. This request must be made in writing and submitted to the Practice Manager. We are required to accommodate only reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Practice Manager. We may refuse to provide you with certain information you request to inspect or copy if the information:

- Includes psychotherapy notes;
- Has been complied in anticipation for use in civil, criminal, or administrative proceedings;
- Is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
- Identifies a person whom information was obtained under a promise of confidentiality.

If you request a copy of your medical information, we are permitted to charge a fee. The Texas State Board of Medical Examiners has established these fees for the costs of copying, mailing, or summarizing your records. Texas law requites we provide these copies or a narrative within 15 days of your request. We will inform you of when the records will be ready or if we believe access should be limited or denied. If access is denied, we will notify you in writing of this decision.

We may deny your request to inspect and copy records in certain limited circumstances. If you are denied access to medical information, including psychotherapy notes, you may request this denial be reviewed. Another licensed health care professional who was not involved in the original decision to deny access will perform this review.

Right to Amend You have the right to request and amendment of your medical information for as along as the information is maintained by this office. To request an amendment you must submit you request in writing along with a reason that supports your request to the Practice Manager.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by this office, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by this office;
- Is part of the information you would not be permitted to inspect or copy;
- Is accurate and complete.

We will respond to your request in writing within 60 days. However, if we refuse to allow an amendment, you are permitted to include a statement about the information in a medical record. If your amendment is accepted, we will work with you to notify other designated individuals of this amendment.

Right to an Accounting of Disclosures You have the right to request an accounting of disclosures. This is a list of disclosures made of your medical information for purposes other than treatment, payment, or health care operations, or disclosures made per a signed authorization by you or you representative. Other limitations may apply as well.

You must submit your request in writing to the Practice Manager. The first accounting of disclosures within any 12-month period will be free of charge. We are permitted to charge a reasonable fee for any additional requests within that same period. You will be notified of the cost involved so that you may withdraw or modify you request before any charge is incurred.

Complaints If you believe your privacy rights have been violated, you may file a complaint with the Practice Manager. You may also send written complaints to the Office for Civil Rights, U.S. Department of Health and Human Services. The Office for Civil Rights may be contacted at:

Region VI, Office for Civil Rights
US Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202

Changes to Our Notices This office reserves the right to change our practices, policies, and procedures and to make the new provisions effective for all protected health information we maintain. Should any change be made, a revised Notice of Privacy Practices will be posted in the office, and made available to you upon your request. *This Notice of Privacy Practices is effective June 8, 2009.*

Facility Referral Disclosure: Manoher L. Gurru, M.D., is an investor in Odessa Regional Medical Center and Basin Health Care Hospital. At times, Dr. Gurru refers patients to ORMC and BHC in connection with their care and treatment. If you should have any questions regarding referrals to ORMC or BHC please contact the Practice Manager at (432) 570-9991.

We strive to provide quality health to all our patients.

Signature of Patient or Representative	Relationship/Authority of Representative	Date

Witness	Date