PATIENT REGISTRATION

Place SD Card Cover label here
Not applicable when using internet kit (78-20000)

Snap Test (Must ☑ one): ☐ **Postal Mail** ☐ **Web Registry** ☐ **Drop Ship**

Patient Information			
Name:	Address:		
Date of Birth: Age:	City:	State:	Zip:
Gender: ☐ Male ☐ Female	Social Security#:	E-mail address:	
Home Phone #:	Cell Phone #:	Work Phone #:	
Height:	Weight:	Neck Size:	
Previously or Currently using PAP: ☐ Yes ☐ No	Currently using supplemental oxygen: ☐ Yes ☐ No		
Special Conditions on Test Night One:	Special Conditions on Test Night Two:	Special Conditions on Test Night Three:	

Primary Insurance		**Secondary / Spouse / Coinsurance**	
Insurance Company:		Insurance Company:	
Policy/Group #: Effective Date:	Address:	Policy/Group #: Effective Date:	Address:
ID # ☐ PPO ☐ HMO		ID # ☐ PPO ☐ HMO	
Name of Insured (if not Patient):		Relationship to insured: ☐ Self ☐ Spouse ☐ Dependant	
Name of Insured Employer:		Phone:	Years Employed:

Patient Assignment of Benefits and Release Authorization

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to SNAP Diagnostics, LLC (SNAP) all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered by SNAP. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize SNAP to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to SNAP any and all plan documents, insurance policy and/or settlement information upon written request from SNAP in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to SNAP to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from SNAP and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with SNAP in any attempts to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

I acknowledge SNAP diagnostics is releasing a Sleep Test Recorder to my possession and that the Recorder is property of SNAP Diagnostics. This recorder is to be returned in operating order by the date indicated by my prescribing practitioner.

I have been trained on the use of the Snap equipment by video, person or written form. I have received a copy of the Notice of Privacy Practices.

Signature of Patient / Guardian **Patient Name (Print)** **Date of Service**

Home Sleep Test Medical Order

snap diagnostics

Fax all pages and copy of insurance card to 847-465-3401 OR upload to Snap Cloud

Patient Name: _____ **Phone:**_____ **DOB:**_____

Provider Information (NOTE: This section outlined in **BOLD** may be replaced by *approved* Electronic Medical Order)	
Practitioner Name:	Address:
Name of Practice:	City:
Phone:	State: Zip:
Fax [to send patient test results]:	E-mail:

By signing below, I attest that based on my examination of the patient and his/her medical history, there is a high probability of Obstructive Sleep Apnea. An unattended, type 3, Home Sleep Test with a minimum of 4 channels (airflow, respiratory effort, SpO2 saturation and heart rate), is medically necessary. No co-morbid conditions including, but not limited to, moderate to severe COPD, CHF, OHS, neurodegenerative disorder or cognitive impairment are present that prevent the patient from home sleep testing.

Test Ordered: Type 3, unattended home sleep test for up to 3 nights or other_____
ICD-10 code: Default to G47.30 or Other Code _____
CPT Code: G0399 or 95806

Provider Signature:	**Date of Order:**

Patient Details (Check all that apply)

Clinical Information:

- ☐ Witnessed apnea events during sleep greater than 10 seconds in duration
- ☐ Disruptive Snoring
- ☐ Gasping / Choking
- ☐ Excessive Daytime Sleepiness
- ☐ Awaken with headache or dry mouth
- ☐ Mood Disorder, Fatigue, inability to concentrate
- ☐ History of Heart Disease
- ☐ Hypertension / High Blood Pressure
- ☐ History of Stroke or family history
- ☐ Craniofacial abnormalities
- ☐ Upper Airway soft tissue abnormalities
- ☐ Non-restorative sleep
- ☐ Disturbed or restless sleep
- ☐ Diabetes

Evaluate for Post Treatment:

Were you previously diagnosed with Sleep Apnea? ☐ Yes *(if yes, Date of last test_____)* ☐ No

Is the re-test *Pre* or *Post* treatment (circle one) Type of Treatment ☐ Surgery ☐ Oral Appliance ☐ PAP Therapy

☐ Is a new study necessary due to changes in BMI >5 or due to significant weight loss (10% or greater of body weight)

☐ New study using therapy to evaluate therapy effectiveness ☐ New study to evaluate need for continued therapy

Epworth Sleepiness Scale *Choose the most appropriate response for each situation* →	**Never would doze off**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
1. Sitting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
2. Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
3. Sitting inactive in a public place	☐ 0	☐ 1	☐ 2	☐ 3
4. As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
5. Laying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
6. Sitting and talking with someone	☐ 0	☐ 1	☐ 2	☐ 3
7. Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
8. In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
Score of All Questions (sum total of all eight responses):				