



Fort Collins Office:
2627 Redwing Rd Suite 300
Fort Collins, CO 80526
Ph: 970-484-0250 Fax: 970-484-
1522

PATIENT INFORMATION

Patient Name _____
Last Name _____ First Name _____ Initial _____
Mailing Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Street Address (if different) _____
Sex ___ M ___ F Age: _____ Birth date: ___/___/____ Social Security# _____
Employer: _____ Occupation _____ Business Phone _____
Spouse or parent name _____ SSN# _____ Birth date ___/___/____
In case of emergency notify _____ Relationship _____ Phone _____

Kindly give a 48 hour notification of canceling an appointment. If you miss your appointment completely a fee may be applied to your account.

INSURANCE INFORMATION

This office cannot guarantee that the insurance company will reimburse patients for services received at this office. In the event an insurance check was sent to our office, a refund will be issued to the patient if there is no outstanding balance. However, if there is a balance owed on the patient's account, assignment of benefits will be made to the provider and any insurance check(s) received will be applied towards the patient's outstanding ledger.

With the exception of workers compensation claims, the patient is responsible for verifying benefits, obtaining referrals or obtaining prior authorizations/certification. Please note, the Craniofacial Pain and Sleep Center will do all that is possible to get coverage by filing with the carrier(s) applicable on behalf of the patient.. Unless prior arrangements are made, payment is due at time of service and acceptable forms of payment are: Cash, Check, Money Order, Credit Cards and Care Credit Financing.

Insurance Company _____ Phone# _____
Billing Address _____ City _____ State _____ Zip _____
Type of policy (Please Circle) Dental Health Worker's Comp Auto Date of Accident _____
Member ID/ Claim# _____ Group# _____ Adjuster's Name _____
Policy Holder's Name: _____ SSN _____ Birth Date _____

ASSIGNMENT/ RELEASE/ CONSENT

I certify that I (or my dependent) have insurance coverage with the above named company. I understand that, unless prior arrangements have been made, payment of insurance benefits will be directed to myself or policy holder (workers comp and MVA excepted). I hereby authorize the doctor to release all information necessary to secure payment of benefits and I authorize the use of this signature on all insurance submissions. Craniofacial Pain and Sleep Center cannot bill your insurance without the appropriate signature below.

I am requesting and consenting to the diagnostic and therapeutic procedures to be performed by Craniofacial Pain and Sleep Center, Dr. Kingdon K. Brady, or staff.

I hereby warrant that I have not been legally adjudged as incompetent. I understand that it is my right to determine the extent of my medical/dental care, and that I may, at any time, refuse treatment and withdraw my consent for the performance of any procedure or treatment. I recognize that no guarantees have been or can be made regarding the likelihood of success or the outcome of any evaluation, treatment, test procedure, or therapy performed by the Craniofacial Pain and Sleep Center physician and/or staff.

Signature

Date

Patient Name _____ Date _____

SLEEP QUESTIONNAIRE

Please check any of the following conditions you now have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Thyroid disorders |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Creutzfeldt Jakob disorder | <input type="checkbox"/> HIV | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Latex allergy | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Low blood pressure | _____ |

List all medications you are currently taking _____

List any medications to which you are allergic _____

List hospitalizations/serious illnesses in the last 2 years _____

1. What is your chief complaint? _____
When did this begin? _____
2. Do you smoke or chew tobacco? _____/week Yes No
3. Do you drink alcohol? _____/week Yes No
4. Do you have high blood pressure? Yes No
5. Have you had a sleep study? Please bring a copy. Yes No
6. Do you snore? Loudness is: Mild Moderate Severe Yes No
7. Do you stop breathing when you are asleep? Yes No
8. Do you wake up gasping for breath? Yes No
9. Do you feel tired in the morning? Yes No
10. Do you awake with a headache? Yes No
11. Do you have stiffness or pain in your jaw joint area? (TMJ) Yes No
12. Do you hear popping/ clicking sounds in your jaw joints? Yes No
13. Do you hear grinding/gravel like sounds in your jaw joints? Yes No
14. Has your jaw ever been locked in an open or closed position? Yes No
15. Does your bite feel off? Yes No
16. Do your jaw muscles feel tired in the morning? Yes No
17. Do you clench or grind your teeth during sleep? Yes No
18. Have you ever had orthodontic treatment? Yes No
19. Average number of hours per night you sleep _____
20. Do you have "restless legs" when you lay down to sleep? Yes No
21. Have you ever worn a mouth appliance? Yes No
If yes: _____ upper _____ lower
Name of Dentist _____
Date received _____
Do you still wear it? If yes, please bring it with you. Yes No

22. Have you tried a C-PAP? Yes No
 With what success? _____
23. Have you tried surgical correction? Yes No
 What type _____
 With what success? _____
24. What other approaches to reducing your snoring/ sleep apnea have you attempted?

25. Comments _____

If available, the following questions should be answered by your sleep partner.
 These questions relate to the behavior you have observed in this patient while he/she is asleep. Use the following scale to choose the most appropriate number for each situation.

- 0 = Never
- 1 = Infrequently (1 night per week)
- 2 = Frequently (2-3 nights per week)
- 3 = Most of the time (4 or more nights per week)

- Loud, obtrusive or irritating snoring _____
- Choking or gasping for air _____
- Pauses in breathing _____
- Twitching/kicking or arms or legs _____
- Snoring requiring separate bedrooms _____
- Falling asleep inappropriately _____
 (i.e. while driving or in meetings)
- Total Score _____

Score of 5 or more indicates symptoms which may affect the health, safety or quality of life of the observed person.

Comments _____

Patient Name _____ Date _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze-off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

- 0 = Would never doze-off
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

Chance of Dozing

Situation

- 1. Sitting and reading _____
- 2. Watching television _____
- 3. Sitting inactive in a public place (i.e. theater) _____
- 4. As a car passenger for an hour without a break _____
- 5. Lying down to rest in the afternoon _____
- 6. Sitting and talking to someone _____
- 7. Sitting quietly after lunch without alcohol _____

- 8. Driving a car, stopped for a few minutes
in traffic or at a red light _____

Total Score _____

A score of 6 or greater indicates the possibility of sleep-disordered breathing.

THORNTON SNORING SCALE

Snoring has a significant effect on the quality of life for many people. Snoring can affect the person snoring and those around him/her, both physically and emotionally. Use the following scale to choose the most appropriate number for each situation. **(Go to question #4 if you do not have a bed partner.)**

- 0 = Never
- 1 = Infrequently (1 night per week)
- 2 = Frequently (2-3 times per week)
- 3 = Most of the time (4 or more nights per week)

Situation

- 1. Snoring affects my relationship with my partner _____
- 2. Snoring causes my partner to be irritable or tired _____
- 3. Snoring requires us to sleep in separate rooms _____
- 4. I am fatigued, exhausted, and feel a lack of energy _____
- 5. I have morning headaches _____
- 6. I lose my concentration and/or fall asleep inappropriately _____
- 7. My sleep does not seem restorative or restful _____
- 8. I feel depressed or “down” _____
- 9. My snoring is loud _____
- 10. My snoring affects people when I am away from
home (i.e. hotel, camping, etc.) _____

Total Score _____

A score of 8 or greater indicates your snoring may be significantly affecting your quality of life.

PHYSICIAN LIST

PATIENT NAME _____ **DATE** _____

It is helpful if this form is filled out as completely as possible. *Dr. Brady will send copies of his initial report to each person listed below.*

Referred by: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Physical Therapist: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Dentist: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Attorney: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Physician: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Other: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Chiropractor: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

Other: _____
Address: _____

Phone: _____
Email: _____
Fax: _____

NOTICE AND ACKNOWLEDGEMENT OF INFORMATION PRACTICES (PRIVACY POLICY & PROCEDURES)

As required by the **Health Information Portability and Accountability Act of 1996 (HIPAA)** Craniofacial Pain and Sleep Center is providing this notice to you. You will be asked to acknowledge receipt of a copy of this information by signing the bottom of this notice.

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.

Your rights under HIPAA:

- **You have the right to request restrictions regarding who has access to your personal or protected health information (PHI).**
- **You have the right of privacy concerning communications regarding your PHI.** Craniofacial Pain and Sleep Center will take reasonable steps to prevent unauthorized disclosure and unauthorized re-disclosure of your PHI without proper authorization.
- **You have the right to inspect and have a copy of your PHI.** *All records contained in the patient's file are the property of Craniofacial Pain and Sleep Center.* If patient requests copies of his/her records, Craniofacial Pain and Sleep Center reserves the right to charge a reasonable fee. All requests must be in writing.
- **You have the right to amend your PHI.** You have the right to amend your PHI if you believe that it is incorrect or incomplete. Craniofacial Pain and Sleep Center will review your request and either grant your request or explain the reason why it will not be granted. In the event your request is granted, Craniofacial Pain and Sleep Center will not destroy an entry, but rather designate it as an error, leaving the original entry legible. In the event your request is not granted, you may submit a statement of disagreement that will accompany the information in question in all future disclosures.
- **You have the right to receive a record of all non-routine disclosures of your PHI.** Disclosures of PHI prior to 4/03 will not be accounted. Records associated with treatment, payment and healthcare operations will not be recorded.
- **You have the right to receive a printed copy of the Notice of Privacy Practices.**
- **You have the right to complain about Craniofacial Pain and Sleep Center's privacy policies, procedures or actions.** Craniofacial Pain and Sleep Center will not retaliate or discriminate against you for submitting a complaint or reporting a suspected violation. Please notify the office staff if you suspect a violation so that we may take the necessary action.

Authorization of use or disclosure of protected health information: Craniofacial Pain and Sleep Center will use and disclose your personal health information for the purposes of treatment, payment and healthcare operations, including, but not limited to, contacting the doctors/attorney you have listed in your file regarding your exam findings and our services. Legally mandated disclosures that may be made without your authorization are for the purposes of: treatment; payment; healthcare operations; law enforcement; public health; reporting of abuse, neglect or domestic violence; subpoena, court order or summons; organ donation; coroner or posthumous medical examination; to avert threats to public/ personal health or safety; disaster relief. Any other use or disclosure of protected health information requires written authorization by the patient and the patient may revoke this authorization in writing at any time.

Craniofacial Pain and Sleep Center Duties: It is the policy of Craniofacial Pain and Sleep Center that all personnel must preserve the integrity and confidentiality of medical and other sensitive information pertaining to our patients. The purpose of this policy is to ensure that Craniofacial Pain and Sleep Center and its officers, employees and agents have the necessary medical and other information to provide the highest quality of care possible while protecting the confidentiality of that information to the highest degree possible so that patients do not fear to provide information to Craniofacial Pain and Sleep Center and its officers, employees and agents for the purposes of treatment. This policy will be reviewed annually.

Craniofacial Pain and Sleep Center recognizes that medical information collected about patients must be accurate, timely, complete and available when needed. Craniofacial Pain and Sleep Center will complete and authenticate medical records in accordance with the law, medical ethics and accreditation standards. Craniofacial Pain and Sleep Center will maintain medical records for the retention periods required by law and professional standards.

All officers, agents and employees of Craniofacial Pain and Sleep Center must adhere to this policy. Craniofacial Pain and Sleep Center will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action.

Right to revise privacy practices: Craniofacial Pain and Sleep Center reserves the right to modify its privacy practices and that should it do so, the revised notice will be made available to patients upon their request.

Privacy Officer for Craniofacial Pain and Sleep Center: Kingdon K Brady - 2627 Redwing Rd. #300 Fort Collins, CO 80526; telephone 970.484.0250.

Effective Date: This privacy policy/procedure is effective on July 15, 2010

Revisions: 1.21.2016

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

I _____ acknowledge receipt of Notice of Information Practices Privacy Policy & Procedures

Signature

Date

FINANCIAL POLICY

Patient Name _____

CONFIRMATION OF ELIGIBILITY

- **We highly recommend that you call the number on the back of your insurance card, prior to your first appointment, to find out whether services are a covered benefit under your medical and/or dental plan.** This will outline what you, the insured, can expect in payment from your insurance company.

PAYMENT

- **Applicable payment is due at time of service.** As a courtesy, we will file commercial insurance for you. If we are contracted with your insurance carrier and the services are a covered benefit, payments will be made directly to the Provider. If we are not contracted with your insurance carrier or the services are not a covered benefit, it has been explained to me that I am responsible for the entire professional fee, and my insurance company is responsible to me. I am responsible for all fees associated with collection on the account should the account become delinquent, including but not limited to attorney & collection agency fees.
- However, if services rendered remain outstanding, the patient agrees that the assignment of benefits will be made to the provider. Please note that any of the insurance check(s) received will be applied to any outstanding balance in the patient's account.
- I understand that there will be additional charges for broken or lost appliances and missed appointments. If you are unable to keep your scheduled appointment, we ask that you kindly contact our office 24 hours in advance.
- **I understand that the initial exam fee does not include the cost of the CT scan.** If I choose not to go forward with treatment, and want the CT scan, there is a \$400.00 records fee to certify and release the scan.

IMPORTANT

- **Dr. Brady is NOT a Medicare or Medicaid provider and, as such, is an "Opt-Out Provider". As a patient of Dr. Brady's, you enter in to a private contract with our office whether or not you are a Medicare, Medicaid and/or any other insurance beneficiary.**
- We are unable to guarantee payment by your insurance carrier, even if the services rendered are a covered benefit.

SIGNED

DATE

INFORMED CONSENT FOR AN ORAL AIRWAY DILATOR APPLIANCE

I, (NAME) _____ have selected treatment for an oral airway dilator appliance while sleeping in an attempt to alleviate snoring and obstructive sleep apnea. The purpose of this appliance is to maintain an open airway passage which permits normal quiet breathing during sleep. I have been told that while this device has had an excellent record in the majority of patients, due to physiological, anatomical variations, and individual tolerance of the appliance, there can be no guarantee that it will be totally successful.

By increasing the vertical intraoral dimension, as well as horizontal advancement of the mandible, your oral appliance dilates the pharyngeal opening and prevents collapse of the tongue on the airway. It repositions the condyles and captures the disc in a physiologic position conducive to ligament healing. The goal of treatment is to prevent reciprocal clicking while it is being worn, and alleviate temporomandibular joint related symptoms. It enlarges tongue space but does not adversely affect swallowing. It allows the masticatory muscles to remain passive, comfortable and not hyperactive.

Certain precautions are recommended to prevent the occurrence of a bite shift. You will be given written and verbal instructions to prevent any bite shift. Your instructions are to remove the lower component 10 to 15 minutes before the upper is removed. During this period we recommend chewing on the upper component in a centric bite position. After removal of the upper you are instructed to try and bite on the posterior teeth. If you are still unable to bite in the centric occlusion position by 10:00AM then we recommend chewing on a piece of sugarless gum. As soon as you feel posterior interocclusal contact, dispose of the chewing gum. This regimen works approximately 98% of the time.

For many patients bite shift is never a problem. Usually it is the patient who does not follow the recommended AM procedures, and therefore develops the posterior open bite. They only bite on the anterior teeth and they cannot get the mandible back to their usual centric occlusal position. This condition is usually asymptomatic. If there is a complaint, it is that they cannot masticate their food as well as before.

It is probable that these patients most likely had an underlying temporomandibular disorder (TMD). Patients with pre-existing conditions, such as a reducing disc displacement and muscle splinting/muscle spasm, may become unable to close into central occlusal after use of an oral airway dilator. Physiologists refer to this condition as a "physiologic set point". The original centric occlusion was an adaptive position that was not as compatible to healthy physiological function as the new position. Therefore, the brain, nerves and reprogrammed muscles refuse to go back to the old position.

An oral airway dilator and muscle deprogrammer, in these rare cases, creates a physiological set point that facilitates better breathing and a more open airway; and the brain, nerves and muscles refuse to close in the old maladaptive centric occlusion. This is not necessarily bad. These patients are probably breathing better and often experience a decrease or disappearance of “TMD” symptoms. Good restorative dental work is often the recommended solution for this rare bite shift.

In addition to the above, I understand and am aware of the following conditions which may occur. Although the oral airway dilator appliance is not intended to change my jaw or teeth, it may happen. If I notice these occurrences, I will contact the office immediately. If I have any dental, jaw or muscle discomfort, other than mild discomfort for the first hour or so in the morning, I will inform the office. Since this appliance is designed to be highly retentive during sleep, existing dental restorations, including crowns and/or bridges may occasionally loosen or fail. If this occurs, I agree to have the necessary dental work attended to as soon as possible.

Oral appliances can wear and break. The rare possibility that broken parts from them may be swallowed or aspirated does exist. For patients with sleep apnea, the device must be worn nightly. Discontinuation of use is a hazard to your health and can lead to a heart attack, stroke, and even death. Should you ever decide not to utilize treatment with your intraoral sleep appliance, consult with your primary care physician or call this office for recommendations of alternative therapy such as CPAP and/or surgery.

The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure snoring or sleep apnea. Therefore, the device must be worn for a lifetime to be effective. Over time, simple snoring may develop into sleep apnea and may become worse. Therefore, the appliance may not maintain its effectiveness. The oral appliance needs to be checked at least twice a year to ensure proper fitting and the mouth examined at that time to assure a healthy condition. If any unusual symptoms occur, you are advised to schedule an office visit to evaluate the situation.

I have received, read, or had read to me, the contents of this form. Further testing and procedures may be necessary and no warranties or guarantee of success was given or implied. Furthermore, I give my permission for my diagnostic and treatment records and photographs to be used for purposes of research, education or publication in professional journals. I also accept financial responsibility for this treatment. With all of the foregoing in mind, I authorize treatment and I have received a copy of this disclosure.

Signature: _____ Date: _____