UB|MD PEDIATRICS

THE PHYSICIANS AT
Oishei Children's Hospital

UBMD PEDIATRICS SLEEP CENTER

Welcome to the UBMD Pediatrics Sleep Center, which is part of the Division of Pulmonology & Sleep Medicine. We are the *only* dedicated pediatric sleep program in Western New York serving patients, infants up to 21 years of age. We are devoted to the diagnosis and therapy of sleep disturbances and disorders.

Symptoms:

- Asthma
- Daytime tiredness
- Difficulty falling asleep
- History of heart problems, acid reflux, diabetes, obesity, or high blood pressure
- Hyperactivity
- Nocturnal gasping or choking
- Snoring
- Witnessed episodes of not breathing

We Treat:

- Obstructive sleep apnea
- Central sleep apnea and sleep-related hypoventilation disorders
- Snoring
- Narcolepsy
- Kleine-Levin Syndrome
- Insomnia
- Hypersomnia
- Parasomnia
- Sleep-related movement disorders
- Circadian rhythm
- Sleep-wake disorders

Sleep Medicine Specialists

Sleep Medicine Specialists are members of the faculty at the University at Buffalo and are board certified in Sleep Medicine. They supervise medical students, residents and fellows on the Sleep Medicine consult service, while also working closely with your primary medical team.

Alberto F. Monegro, MD

Amanda Hassinger, MD, MS

Locations	Contact Information	About Us
Pediatric Sleep Clinic Conventus 1001 Main Street, 4th Floor Buffalo, NY 14203 University Commons 1404 Sweet Home Road Suite 5 Amherst, NY 14228 **Pediatric Sleep Lab** Oishei Children's Hospital 818 Ellicott Street, 2nd Floor Buffalo, NY 14203	**716.323.0370** **716.323.0296** **UBMDPediatrics.com**	UBMD Pediatrics is one of 18 practice plans within UBMD Physicians' Group. We provide premier health care to infants, children, adolescents, and young adults throughout Western New York and beyond. Our doctors make up the academic teaching faculty within the Department of Pediatrics at the Jacobs School of Medicine and Biomedical Sciences at the University at Buffalo and are also the physicians at Oishei Children's Hospital.

Partnered with Sleep & Wellness Centers

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MEET YOUR SLEEP TEAM

PROVIDERS

This team of doctors at the UBMD Pediatrics Sleep Center will oversee your medical care and be available to you to ensure you have the best experience during your evaluation and management of your sleep problems.

Alberto F. Monegro, MD

Amanda Hassinger, MD, MS

*See them in the Pediatric Sleep Clinic in Conventus (1001 Main Street, 4th Floor, Buffalo, NY 14203)

TECHNOLOGISTS OF SLEEP & WELLNESS CENTERS

They are your partner in facilitating sleep studies at the Sleep Lab, if applicable. They will help with both the scheduling of your studies and submitting any testing reports to your primary care doctor.

Phone: 716.691.6283

*See them in the Pediatric Sleep Lab in Oishei Children's Hospital (818 Ellicott Street, 2nd Floor, Buffalo, NY 14203)

DURABLE MEDICAL EQUIPMENT (DME)

They are the supply company of your choosing that will help you obtain a comfortable face mask and appropriate machine, if indicated. They are your resource in obtaining repair or replacements of supplies, such as tubing.
Below are a few DME companies in the area:

Apnea Care
716.923.2727

Bensons Surgical Supply
Buffalo: 716.332.0404 | Williamsville: 716.748.7397

Buffalo CPAP
716.206.0208

C-Pap Xpress
716.633.2788

Dove Medical
716.688.8911

Health System Services
716.283.4879

Preferred Home Care, Inc.
716.433.6408

Pro2 LLC
716.667.9600

Sheridan Surgical
716.836.8780

Respiratory Services of WNY
716.683.6699

ADDITIONAL PROVIDERS FROM OTHER SPECIALTIES

Often we work as a team with other health care providers who may also be involved in your care.
These specialties include:

- Dentistry
- Ear, Nose & Throat (ENT)
- Gastroenterology & Nutrition
- Genetics
- Oral and Maxillofacial Surgery
- Plastic Surgery
- Primary Care
- Psychiatry
- Psychology
- Pulmonology
- Speech Therapy

UB|MD PEDIATRICS

PEDIATRIC SLEEP QUESTIONNAIRE FOR NEW PATIENTS

Please answer the following questions by filling in the blanks or checking the appropriate responses. You may omit questions that you do not feel like they apply to your child or that you do not wish to answer. Your cooperation is appreciated and your confidentiality assured.

Today's Date: _____

PATIENT INFORMATION

Child's Name: _____ Sex: _____ M _____ F

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address: _____

Phone Number: ( ) _____ Work Number: ( ) _____

REFERRING PHYSICIAN

Physician Name: _____

Address: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

If there is another physician that you would like us send a copy of your report, you must provide us with the full name and address below:

Physician Name: _____

Address: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

CLINICAL HISTORY

Please describe the reason(s) you sought or are seeking this evaluation for your child:

_____

_____

Has your child had a previous sleep study? ___ Yes ___ No

If yes, where was the study done? _____ Date of Study: _____

Has your child had an ENT evaluation? ___ Yes ___ No Name of ENT: _____

Has your child had an adenoidectomy/tonsillectomy? ___ Yes ___ No Date: _____

What have you seen your child do while they are asleep?

Problem	No	Yes	Days per week	If yes, age of onset
Do you have any concerns about your child's breathing while sleeping?				
Does your child snore?				
Does your child choke and/or gasp for air while sleeping?				
Does your child stop breathing during sleep?				
Have you ever had to or want to shake your child to help them breathe again when sleeping?				
Does your child struggle to breathe during sleep?				
Does your child mouth breathe or have trouble breathing through their nose?				
Does your child drool at night?				
Is your child a restless sleeper?				
Does your child have frequent leg movements or kick while asleep?				
Does your child grind their teeth while asleep?				
Any history of walking while asleep?				
Any body rocking/head banging?				
Does your child wake up frightened and/or screaming in the middle of the night?				
Any bed-wetting (if potty-trained)?				

If your child snores, how loud is it?	Very quiet	Soft but audible	Loud	Very loud	Wakes the house

Has your child been diagnosed with any of these medical conditions?

Problem	No	Yes	If yes, age of onset	Any treatment of surgery?
Enlarged tonsils				
Enlarged adenoids				
Nasal allergies/hay fever				
Asthma				
Frequent cold/sore throat				
Frequent ear infections				
Frequent morning headaches				
Excessive weight gain				
Failure to gain weight				
Stomach acid reflux				
Neurologic or muscular disorder				

Genetic disease				
Craniofacial disorder				
Developmental disability				
Hyperactivity				
Difficulties in paying attention				
Irritability or mood swings				
Recent decrease in school performance				
Frequent leg pain or discomfort				
Frequent rubbing of legs				
ANY OTHER DIAGNOSED ABNORMALITIES:				

SLEEP HISTORY

What time does your child go to bed on weekdays? _____ Weekends? _____

What time does your child wake up on weekdays? _____ Weekends? _____

How long does your child read, watch TV or do other activities after going to bed? _____ minutes

How long does it usually take your child to fall asleep after all activities are over? _____ minutes

On an average night, how many times does your child wake up?

_____ Never
_____ 1-2 times
_____ 3-4 times
_____ 5-6 times

If your child does wake up during the night, how long does it take for him/her to go back to sleep?

_____ 10 minutes or less
_____ 10-30 minutes
_____ 30-60 minutes
_____ More than 60 minutes

How many days a week does your child wake up early and then cannot go back to sleep?

_____ Never
_____ 1-2 days per week
_____ 3-4 days per week
_____ 5 or more days per week

How would you describe the quality of your child's sleep?

_____ Excellent
_____ Good
_____ Fair
_____ Poor

What is your child's usual sleeping position?

_____ Stomach
_____ Side
_____ Back
_____ Propped up with pillows

How many nights a week does your child sleep in the same room as you or another primary caretaker?

_____ 1-2 days per week
_____ 3-4 days per week
_____ 5+ days per week
_____ Does not apply

Is your child excessively sleepy or tired during the day? ___ Yes ___ No

How often does your child take naps?

_____ Rarely or never
_____ 1-2 days per week
_____ 3-4 days per week
_____ 5+ days per week

_____ More than once a day

If your child naps, how long do the naps last?
_____ 10-30 minutes
_____ 30-60 minutes
_____ 1-2 hours
_____ More than 2 hours

Is there anything else that is unusual about your child's sleeping or breathing during sleep?

_____

_____

MEDICATION HISTORY

Is your child presently taking any prescription or non-prescription medications (other than vitamins)? ___ Yes ___ No

If yes, please list:

Medication Name	**Amount**	**How Often?**

Has your child taken any antibiotics in the past four weeks? ___ Yes ___ No

If yes, name of drug: _____ Date of most recent dose: _____

EPWORTH SLEEPINESS SCALE-CHILDREN

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times even if you have not done some of these things recently.

Use the following scale:
0 = Would never doze off or fall sleep
1 = *Slight* chance of dozing or sleeping
2 = *Moderate* chance of dozing or sleeping
3 = *High* chance of dozing or sleeping

Circle the most appropriate number for your child in each situation:				
1. Sitting and reading (or being read to)	0	1	2	3
2. Watching television (or a computer)	0	1	2	3
3. Sitting inactive in a public place (i.e. movie theater, waiting room)	0	1	2	3
4. As a passenger in a car for 1 hour without a break	0	1	2	3
5. Lying down to rest outside of nap time	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after a meal	0	1	2	3
8. Doing school work or taking a test	0	1	2	3

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SERVICES FORM

PATIENT NAME: _____

PHONE #: _____

SECONDARY PHONE #: _____

E-MAIL ADDRESS: _____

EMERGENCY CONTACT INFORMATION (i.e. SPOUSE, GRANDPARENT, FRIEND)

EMERGENCY CONTACT NAME: _____

PHONE #: _____

RELATIONSHIP TO CHILD: _____

RACE (PLEASE CHECK)

_____ BLACK AFRICAN AMERICAN

_____ ASIAN AMERICAN

_____ AMERICAN INDIAN, ALASKA NATIVE

_____ CAUCASIAN

_____ NATIVE HAWAIIAN, OTHER PACIFIC ISLANDER

_____ UNKNOWN

_____ OTHER (PLEASE SPECIFY): _____

ETHNICITY (PLEASE CHECK ONE)

_____ HISPANIC OR LATINO

_____ NOT HISPANIC OR LATINO

_____ UNKNOWN

PRIMARY LANGUAGE (PLEASE CHECK ONE)

_____ ENGLISH

_____ BURMESE

_____ SPANISH

_____ RUSSIAN

_____ OTHER (PLEASE SPECIFY): _____

UB|MD PEDIATRICS

Date: _____

CONSENT FOR TREATMENT

Patient Name: _____

Parent or Guardian (if patient is under 18): _____

I hereby voluntarily consent to and/or authorize the performance of medical examinations, treatments, diagnostic procedures, blood tests, and/or laboratory procedures, which the doctor(s) in attendance at the UBMD PEDIATRICS OUTPATIENT CENTER considers medically necessary and/or appropriate.

I acknowledge that no guarantees have been made as to the effect of such examinations or treatments on my or my child's condition.

This consent will remain in effect for as long as the patient remains a client of the UBMD Pediatrics Outpatient Center.

_____ _____

Patient or Parent/Guardian Signature | Parent/Guardian Relationship to Patient

_____ _____

Witness | Date

UB|MD PEDIATRICS

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of UBMD Pediatrics' Notice of Privacy Practices.

_____

Signature

_____

Name or Personal Representative

_____

Date

_____

Relationship to Patient

**********FOR OFFICE USE ONLY**********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ Emergency situation prevented us from obtaining acknowledgement

_____ Other (Please specify: _____)

UB|MD PEDIATRICS

HIPAA

(Health Insurance Portability and Accountability Act)

AUTHORIZATION TO SHARE PHI

Disclosure of Protected Health Information

You have a right to request that we share certain information about your health care with family members or friends that may be involved in your care. You may also request limitations on how we disclose information about you to family or friends involved in your care. We will not share information such as test results, prescription refills, or appointments with anyone unless you authorize us to do so. Please indicate below with whom we may share certain health information. You also have the right to revoke this authorization, in writing, at any time.

PATIENT INFORMATION

Patient Name: _____ DOB _____/_____/_____

Telephone (daytime): _____ (evening): _____

AUTHORIZATION REQUESTED (With whom can we share health information?)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

WHAT KIND OF HEALTH INFORMATION ARE YOU AUTHORIZING US TO SHARE?

Please place an X next to the information that can be shared:

_____ Make appointments for me
_____ Test results can be shared
_____ Call for prescription refills
_____ My overall health status

Other (Please specify: _____)

NOTIFICATIONS

With my consent, UBMD Pediatrics may call my home or other designated location, including those listed on my demographic page, and leave a message on voicemail, answering machine or in person in reference to items, such as appointment reminders, insurance information. Any restrictions are listed below:

_____

PATIENT UNDERSTANDING AND SIGNATURE

By signing below I am authorizing UBMD Pediatrics to share the indicated health information with those listed above.

_____ _____
Signature Patient Name or Personal Representative

_____ _____
Description of Personal Representative's Authority Date

UB|MD
PHYSICIANS' GROUP

MyUBMD
Pediatric Proxy Access Request

Please read this form carefully before signing. This authorization will permit your healthcare provider to release portions of your electronic medical record information to you, as a parent or legal guardian. The use of MyUBMD Patient Portal powered by FollowMyHealth is voluntary.

As a proxy for your child (ages 0-12 years), you will have access to his/her medical record and the ability to send messages to providers, refill prescriptions and request appointments.

As a proxy for your child (ages 13-17 years), you will only have the ability to send messages to providers, refill prescriptions and request appointments. New York State law requires that your child's healthcare providers keep information about certain protected health conditions confidential even from you. As part of our compliance with this law, we refrain from passing medical record updates from your child's record after he/she reaches the age of 13.

On your child's 18th birthday, he/she will be able to create his/her own account to have access to his/her own medical record. On your child's 18th birthday, the parent or legal guardian will only be able to access historical data and can no longer message providers.

Both parents/legal guardians are allowed to have access to the FollowMyHealth patient portal. Please note that the patient's information will be accessed through your MyUBMD account.

Return completed forms to the healthcare provider from whom this form was obtained.

Child's Information (All sections required—Please print clearly.)

Patient's Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Your (Proxy) Information (All sections required—Please print clearly.)

Your Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Relationship to Patient (Circle one): Parent Guardian

FollowMyHealth Terms and Conditions: I certify that I am the birth/adoptive parent or legal guardian of the individual listed above and that all information I have provided is correct.

_____/_____/_____

Your (Proxy) Signature | Relationship to Patient | Date

The use of MyUBMD is governed by the FollowMyHealth Proxy Terms and Conditions of Use, a copy of which may be accessed when you sign in to your FollowMyHealth account and whose terms are incorporated herein. By signing above, you agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use. If, for any reason, you do not agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use, FollowMyHealth proxy access will immediately be terminated. Following termination, you have the right to request in writing health information which you are legally entitled to access in accordance with New York law. If, at any time after proxy access is granted, your relationship to the patient changes such that you no longer have the legal right to access his/her health information, you will immediately cease accessing any information regarding the patient in FollowMyHealth chart and notify your healthcare provider's office of the change of circumstances.

SECURITY CODE/PASSWORD IS PATIENT'S BIRTH YEAR: _____

UB|MD
PHYSICIANS' GROUP

MyUBMD
Adult Proxy Access Request

Please read this form carefully before signing. This authorization will permit your healthcare provider to release portions of your electronic medical record information to the person listed on page 1 of this form. I understand that the use of MyUBMD Patient Portal powered by FollowMyHealth is voluntary. I am not required to use MyUBMD or authorize a proxy.

This form is an authorization that will permit your healthcare provider to release your (patient) electronic medical record information to the adult you have designated and authorized to access your MyUBMD FollowMyHealth account. You have the opportunity to opt out of or revoke the access at any time.

To request access to the record of an adult through MyUBMD, please complete this form. The patient whose information you are requesting to access must sign this form. Please note that the patient's chart will be accessed through your MyUBMD account.

Return completed forms to the healthcare provider from whom this form was obtained.

Patient's Information (All sections required—Please print clearly.)

Patient's Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Your (Proxy) Information (All sections required—Please print clearly.)

Your Name (last, first, middle initial): _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (_____)_____ Email: _____

Access Level (Circle one): Full Access Read Only

FollowMyHealth Terms and Conditions: I hereby designate the person named above as my FollowMyHealth proxy, thereby allowing him/her access to my FollowMyHealth medical record.

_____/_____/_____
Signature of Patient or Authorized Person | Relationship to Patient | Date

_____/_____/_____
Your (Proxy) Signature | Relationship to Patient | Date

The use of MyUBMD is governed by the FollowMyHealth Proxy Terms and Conditions of Use, a copy of which may be accessed when you sign in to your FollowMyHealth account and whose terms are incorporated herein. By signing above, you agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use. If, for any reason, you do not agree to be bound by the FollowMyHealth Proxy Terms and Conditions of Use, FollowMyHealth proxy access will immediately be terminated. Following termination, you have the right to request in writing health information which you are legally entitled to access in accordance with New York law. If, at any time after proxy access is granted, your relationship to the patient changes such that you no longer have the legal right to access his/her health information, you will immediately cease accessing any information regarding the patient in FollowMyHealth chart and notify your healthcare provider's office of the change of circumstances.

SECURITY CODE/PASSWORD IS PATIENT'S BIRTH YEAR: _____

UB|MD PEDIATRICS

FINANCIAL POLICY

We are committed to providing you with the best care, and we are happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important. Please ask if you have any questions about our fees, financial policy, or your responsibilities.

At the time of service, **ALL PATIENTS** must present the following documentation:

1. PATIENT'S current insurance card

2. In accordance with HIPAA regulations, we maintain the right to request social security numbers; however, you have the right to decline to give the information.

Our receptionists will ask you to verify information at each visit. You will also be asked to confirm current address and phone number. We accept **CASH, PERSONAL CHECKS, MONEY ORDERS, VISA, & MASTERCARD** for all out-of-pocket expenses which include copayments, deductibles, and balances due. These expenses cannot legally be waived by our practice, as it is part of the contract between you and your carrier.

1. **INSURANCE PROGRAMS THAT CONTRACT DIRECTLY WITH US:** Blue Cross/Blue Shield, Independent Health, Univera, United HealthCare, Medicare, Medicaid, Community Care, Medisource, Your Care, and Fidelis.

   - You are responsible for understanding the policy you have chosen and for providing our office with all necessary billing information.

   - COPAYMENT IS REQUIRED AT THE TIME OF YOUR VISIT. If you do not have your copayment at the time of your visit, you may be asked to reschedule your appointment.

2. **IF YOU DO NOT HAVE INSURANCE OR BELONG TO AN INSURANCE PROGRAM THAT DOES NOT CONTRACT DIRECTLY WITH US, YOU WILL BE EXPECTED TO PAY THE FOLLOWING FEES AT THE TIME OF SERVICE:**

   - $256 as a down payment for a visit as a NEW patient. Depending on the level of services you received, you may owe more or less than this amount. If you do not have this payment at the time of service, you may be asked to reschedule your appointment. At the time of service, our financial policy and the amount due should be explained to you and noted on your registration.

     PLEASE NOTE: The first time consulting with a sub-specialist is considered a new visit, even if your child may have received a consultation from another UBMD Pediatrics sub-specialty in the past.

   - $78 for a visit as an ESTABLISHED patient. Depending on the level of services performed, you may owe more or less than this amount. If you do not have this payment at the time of service, you may be asked to reschedule your appointment. Our financial policy and the

amount due at the time of service should be explained to you and noted on your registration.

If the total charges for the date of service are more than what you paid at the time of service you will be responsible for the difference.

If the total charges are less than what you paid at the time of service you will be refunded the difference within 30 days.

If UBMD Pediatrics does not contract directly with your insurance company, the Billing Department will submit a courtesy claim to your insurance company. You will need to contact your insurance company to ensure prompt payment. The balance will remain your obligation.

PLEASE NOTE: A $30 fee will be applied for ALL RETURNED CHECKS.

3. MEDICAID MANAGED CARE AND MEDICAID PROGRAMS

- Every Managed Care/Medicaid patient must show a current Medicaid card at the time of service.

- If your insurance plan requires a current referral, you are required to provide our office with a current referral PRIOR to your appointment date. IF YOU DO NOT PROVIDE US WITH THIS INFORMATION, YOUR APPOINTMENT MAY BE RESCHEDULED.

4. APPOINTMENT CANCELLATION POLICY

We require a 48-hour notice of cancellation for all scheduled appointments. If you fail to notify this office, you may be charged $35.

You will receive a billing statement for balances that are not paid. Payment is expected upon receipt of statement. Accounts with outstanding balances will be forwarded to our collection agency as necessary.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our business office by calling 716.932.6060 ext. 102. This will avoid misunderstandings and enable you to keep your account in good standing.

We are not party to any legal agreement between divorced or separated parents. Any financial arrangements between divorced or separated parents must be worked out between those parties.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES, AND I AGREE TO ACCEPT RESPONSIBILITY FOR ANY FINANCIAL OBLIGATIONS INCURRED.

_____ _____

Signature Date