

**James P. Loftin, M.D.**

**Melissa L. Tompkins, M.D.**

**Vivek A. Padegal, M.D.**

**Dallas Location: 9 Medical Parkway, Suite 208, Dallas 75234 (972) 394-2971**

**Carrollton Location: 4333 N. Josey Ln., Suite 203, Carrollton 75010 (972) 394-2971**

**Plano Location: 6124 W. Parker Rd., Suite 330, Plano 75093 (972) 378-3272**

Dear New Patient;

It is **very important** that you complete the following questionnaire for the appointment you have scheduled on \_\_\_\_\_ . By answering all of the questions as completely as possible before your appointment, you will save considerable time in the doctor's office. If you do not complete this paperwork prior to your appointment, **please arrive an hour early to do so.**

When you arrive for your appointment, please present a current insurance card to the receptionist. If your insurance plan requires a referral from your primary care provider, please bring it with you. **If no referral is presented, the receptionist will have to re-schedule your appointment.** If you do not know if your insurance plan requires a referral, call the benefits phone number on your insurance card and ask.

**Please call twenty-four hours in advance if you are unable to keep your appointment.** Since there are a limited number of new patient appointment times per week, many patients wait one or two months for an appointment. When a new patient does not show up for an appointment or reschedules less than 24 hours in advance, there is not enough time to call a patient who has been waiting for an appointment. Therefore, **due to the high increase in the number of patients not showing up for their scheduled appointment**, if you do not show up for your appointment or reschedule less than 24 hours before your appointment, **we will not be able to reschedule your appointment for a later date and you will need to find another doctor; or, you may schedule an appointment with the doctor after paying a \$95.00 no-show fee.**

If you have any questions, please call the office where you are scheduled. We look forward to your first visit with our caring staff.

Sincerely,

James P. Loftin, MD

Vivek A. Padegal, MD

Melissa L. Tompkins, MD

Kathy Deans, PA-C



LIST ALL SURGERIES:

YEAR:

\_\_\_\_\_  
\_\_\_\_\_

MEDICAL ALLERGIES:

\_\_\_\_\_

**SLEEP HISTORY**

Describe in detail what your sleep problem is and how long this has been a problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Normal Bedtime:                      Weeknights \_\_\_\_\_                      Weekends \_\_\_\_\_  
Normal Wake Up Time                      Weeknights \_\_\_\_\_                      Weekends \_\_\_\_\_  
When you awake in the morning do you feel refreshed?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
How long does it usually take you to fall asleep once the lights are turned off? \_\_\_\_\_  
Do you awaken during the night?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
How long does it take for you to return to sleep upon these awakenings? \_\_\_\_\_  
Do you take naps during the day?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, How often? \_\_\_\_\_ Average Length: \_\_\_\_\_  
Do you feel refreshed upon awakening from these naps?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Note the positions you normally sleep in:                      Back \_\_\_\_\_ Right Side \_\_\_\_\_ Left Side \_\_\_\_\_ Stomach \_\_\_\_\_  
Are you now, or have you ever been, under the care of a cardiologist? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you suffer from a racing heart or an irregular heartbeat?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you suffer from dizziness, light-headedness, or fainting spell?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you ever experience chest pains?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever had a heart attack or mild cardiac infarction?                      Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you ever been diagnosed with a disorder of the central nervous system                      Yes \_\_\_\_\_ No \_\_\_\_\_

Please circle one of the following:

0= Not at all                      1= Mild/very rarely/soft                      2= Moderate/Occasionally                      3= High/Frequently/Loud

1. Do you snore?	0	1	2	3
2. Do you snore while lying on your back?	0	1	2	3
3. Do you snore while lying on your side?	0	1	2	3
4. Rate your snoring.	0	1	2	3
5. Do you hold your breath or stop breathing in your sleep?	0	1	2	3
6. Do you have difficulty breathing while lying on your back?	0	1	2	3
7. Do you have difficulty breathing while lying on your side?	0	1	2	3
8. Do you awaken suddenly with a choking sensation or out of breath?	0	1	2	3
9. Do you have gas, indigestion or heartburn at night?	0	1	2	3
10. Do you have night sweats?	0	1	2	3
11. Do you awaken with headaches in the morning?	0	1	2	3
12. Do you awaken with a dry mouth?	0	1	2	3
13. Do you have trouble breathing through your nose?	0	1	2	3
14. Do you experience shortness of breath with exertion?	0	1	2	3
15. Do you awaken at night to urinate?	0	1	2	3
16. When you awaken from sleep, do you ever feel paralyzed unable to move even though you are awake?	0	1	2	3
17. When someone startles you or makes you laugh, do you get weak, fall or do your knees buckle?	0	1	2	3
18. While in the process of falling asleep, do you have vivid dreams or hallucinations?	0	1	2	3
19. Do you have frequent uncontrollable bouts of sleep, sleep attacks or an irresistible urge to sleep:	0	1	2	3
20. Do your legs kick or twitch frequently during the night?	0	1	2	3
21. Do you have restless legs?	0	1	2	3
22. Do you have problems with memory or concentration?	0	1	2	3

23. Problems with impotence or lack of sexual interest?	0		2	3
24. Are you irritable?	0	1	2	3
25. Do you feel depressed?	0	1	2	3
26. Do you feel anxious?	0	1	2	3
27. Do you grind your teeth at night?	0	1	2	3
28. Do you feel sleepy during the day?	0	1	2	3
29. Do you feel fatigued during the day?	0	1	2	3
30. Do you have to fight sleep while driving?	0	1	2	3
31. Have you ever had a car wreck caused by sleepiness?	0	1	2	3

Please rate the chance of you dozing in the following situations:

- 0= never doze
- 1= slight chance of dozing
- 2= moderate chance of dozing
- 3= high chance of dozing

Sitting and reading \_\_\_\_\_

Watching T.V. \_\_\_\_\_

Sitting inactive in a public place, i.e. theater or meeting \_\_\_\_\_

As a passenger in a car for a rest in the afternoon \_\_\_\_\_

Lying down for a rest in the afternoon \_\_\_\_\_

Sitting and talking to someone \_\_\_\_\_

In a car while stopped for a few minutes in traffic \_\_\_\_\_

Sitting quietly after lunch without alcohol \_\_\_\_\_

Add the numbers for a total                      TOTAL \_\_\_\_\_

**SLEEP ENVIROMENT**

Do you sleep in a waterbed?                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Do you read in bed?                                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Do you watch T.V. in bed?                              Yes \_\_\_\_\_                      No \_\_\_\_\_

Do you share the bed with anyone?                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Does your partner have a sleep disorder?                      Yes \_\_\_\_\_                      No \_\_\_\_\_

Do you have pets in the bedroom? Yes \_\_\_\_\_ No \_\_\_\_\_

What is the temperature in your bedroom? \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Other

What is your present occupation? \_\_\_\_\_

What are your work hours? \_\_\_\_\_

Have you ever smoked? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, for how many years? \_\_\_\_\_

Average number of packs per day \_\_\_\_\_

Have you quit smoking Yes \_\_\_\_\_ No \_\_\_\_\_

How long ago? \_\_\_\_\_

Do you drink caffeinated beverages? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, how much per day? \_\_\_\_\_

Do you drink alcoholic beverages? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, how often? \_\_\_\_\_

Do you get regular exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, how often? \_\_\_\_\_

Do you have any unusual eating habits? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, explain \_\_\_\_\_

**FAMILY HISTORY**

Children:            Number \_\_\_\_\_ Ages \_\_\_\_\_ Health \_\_\_\_\_

Mother:            Living \_\_\_\_\_ Yes \_\_\_\_\_ No Age \_\_\_\_\_ Health \_\_\_\_\_

Father:            Living \_\_\_\_\_ Yes \_\_\_\_\_ No Age \_\_\_\_\_ Health \_\_\_\_\_

Brothers:           Ages: \_\_\_\_\_ Health \_\_\_\_\_

Sisters:            Ages: \_\_\_\_\_ Health \_\_\_\_\_

Does any member of your family have sleep problems? If so, please describe:

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Now that you have answered your questionnaire, do you have any other comments that you would like to add?

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## PATIENT INFORMATION FORM

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ SEX: M F

SOCIAL SECURITY NUMBER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ REFERRING DR.: \_\_\_\_\_

GUARANTOR NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ DAYTIME PHONE: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ POLICY NO.: \_\_\_\_\_

GROUP NO.: \_\_\_\_\_ INSURED NAME: \_\_\_\_\_

PHONE NO.: \_\_\_\_\_ PRIMARY INS. ADDRESS: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ POLICY NO.: \_\_\_\_\_

GROUP NO.: \_\_\_\_\_ INSURED NAME: \_\_\_\_\_

PHONE NO.: \_\_\_\_\_ SEC. INS. ADDRESS: \_\_\_\_\_ Barbara Ragsdale \_\_\_\_\_

### **BENEFITS ASSIGNMENT AND MEDICAL RECORDS RELEASE**

I authorize payment of medical benefits to the treating physician or supplier for these services and all future claims.

Signature of Patient or Guarantor: \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim and all future claims.

Signature of Patient or Guarantor: \_\_\_\_\_

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## **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 uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

### **A. Treatment, Payment, Health Care Operations**

#### **Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

#### **Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

#### **Health Care Operations**

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. Some examples are business associates such as vendors and/or contractors used for billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories, other free standing diagnostic facilities and legal counsel. The physicians require all business associates to appropriately protect the confidentiality of your private health information.

### **B. Disclosures That Can Be Made Without Your Authorization**

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

### **Public Health, Abuse or Neglect, and Health Oversight**

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to 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 medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

### **Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

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

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

### **Workers' Compensation**

We may disclose your medical information as required by workers' compensation law.

### **Inmates**

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

### **Military, National Security and Intelligence Activities, Protection of the President**

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

### **Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors**

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

### **Required by Law**

We may release your medical information when the disclosure is required by law.

## **C. Your Rights Under Federal Law**

The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

### **Requested Restrictions**

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

### **Receiving Confidential Communications by Alternative Means**

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

### **Inspection and Copies of Protected Health Information**

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

#### **Amendment of Medical Information**

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

#### **Accounting of Certain Disclosures**

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

#### **D. Appointment Reminders, Treatment Alternatives, and Other Benefits**

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

#### **E. Complaints**

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

#### **F. Our Promise to You**

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

#### **G. Questions and Contact Person for Requests**

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Barbara Ragsdale  
6124 W. Parker Rd.  
MOB 3, Suite 330  
Plano, TX 75093

This notice is effective September 1, 2009.

## **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority