uNITE SLEEP INSTITUTE NEW PATIENT PACKET
Phone: 775-433-0257 **Fax:** (775) 201-8376
Address: 2145 Green Vista Dr #112, Sparks, NV 89431
Reno: 5315 Reno Corporate Drive, Suite 100, Reno NV. 89511
Las Vegas: 3272 E. Sunset Rd. Suite 100 Las Vegas NV 89120

PATIENT INFORMATION			
Name:		Date of Birth:	
Address:	City:	State:	ZIP:
Home Number:	Cell Number:		
Parent or guardian if under 18 years old:	Emergency contact:	Phone:	

Please describe your sleep issues: _____

_____

_____

MEDICAL HISTORY: (Have you ever been diagnosed with any of the following? Check all that apply)			
Asthma	☐	History of Sleep Apnea or CPAP	☐
Anxiety Disorder (anxiety attacks)	☐	Snoring	☐
Atrial Fibrillation	☐	Insomnia	☐
Bipolar Disorder	☐	Trouble Breathing Through Nose	☐
COPD or Emphysema	☐	Obesity/ Weight Gain	☐
Daytime Sleepiness	☐	Restless Leg Syndrome	☐
Depression	☐	PTSD	☐
Diabetes	☐	Stroke	☐
GERD/ Heartburn	☐	Thyroid Disorder	☐
Heart Disease/ Heart Attack	☐	Seizures	☐
High Blood Pressure	☐	Frequent Bathroom use	☐
Cancer - Please describe type and treatment received:			

Please list any other Medical Conditions that you have or have had: _____

_____

List any other Cardiovascular Conditions that you have or have had in the past: _____

_____

_____

Family History: (Check All That apply in a parent, sinling, or child)			
Alzheimer's Diseaseor Dementia	☐	Narcolepsy	☐
Anxiety/ Depression	☐	Obesity	☐
Asthma	☐	Periodic Limb Movement Disorder	☐
Atrial Fibrillation or Irregular Heartbeat	☐	PTSD	☐
BiPolar Disorder	☐	Restless Leg Syndrome	☐
COPD/ Emphysema	☐	Seizure Disorder or Epilepsy	☐
Diabetes	☐	Sleep Apnea	☐
Heart Disease/ Heart Attack	☐	Stroke or TIA	☐
High Blood Pressure	☐	Thyroid Disorder	☐
Insomnia or Other Sleep Disorder	☐	Other:	

Please List all prescription medications that you take: _____

_____

_____

_____

_____

Please list any non-prescription medications and supplements that you take: _____

_____

_____

_____

_____

Sleep History:		
During the Week		
What time do you normally go to bed on weeknights?	What time do you normally get out of bed on weekdays?	
Do you nap on weekdays?	What time do you nap?	How long are your naps?
On Weekends		
What time do you normally go to bed on weekends?	What time do you get out of bed on weekends?	
Do you nap on weekends?	What time do you nap?	How long are your naps?
Sleep Hygiene		
Do you watch television in bed prior to going to sleep?	How long is the television left on?	
Do you read in bed prior to sleeping?	How long do you read in bed prior to turning the lights off?	

Have you ever been told that you do or do you know that you do any of the following? (Check all that apply)	
Talk in you sleep	☐
Walk in your sleep	☐
Physically act out your dreams in your sleep?	☐
Have you ever awakened to find that you had eaten after going to sleep with no memory of having gotten up to eat?	☐
Wake while sleeping and find that you are in a different location other than where you went to sleep at.	☐
Snore	☐
Stop Breathing	☐
Move your legs or arms repeatedly in sleep	☐
Sweat excessively	☐
Kick or move frequently	☐
Have tingling in your arms or legs.	☐
Grind your teeth when sleeping?	☐
Nightmares or scary dreams	☐

Social Activities:	
Do you smoke cigarettes or cigars?	Did you in the past?
Have you quit smoking?	How long ago?
Do you drink alcoholic beverages?	How many a day?
Do you use any recreational drugs? If so, please explain	
How much caffeine do you consume in an average day?	How much caffeine do you consume after 2 pm?
Do you exercise daily? If so please describe type, frequency and at what times of the day.	

Epworth Sleepiness Score

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep.

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping

3 = high chance of dozing or sleeping

Situation:	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total score:	0

Functional Outcomes of Sleep Questionnaire

1. Do you generally have difficulty concentrating on the things you do because you are sleepy or tired?
2. Do you generally have difficulty remembering things because you are sleepy or tired?
3. Do you have difficulty finishing a meal because you become sleepy or tired?
4. Do you have difficulty working on a hobby (for example: sewing, collecting, gardening) because you are sleepy or tired?
5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?
6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?
7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?
8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?

uNITE Sleep Institute – No-Show & Cancellation Policy

At uNITE, we believe in respect—for your time, our team's time, and the time of the next patient waiting for care. Every appointment is an opportunity to deliver brighter days through better sleep, and we carefully reserve that time just for you.

To help us stay on schedule and deliver exceptional care to everyone, we've established the following cancellation and no-show policy.

Appointment Reminders:
We'll send reminders before your appointment, but ultimately, it's your responsibility to arrive on time and prepared. If you need to make a change, just give us a call—we're here to help.

Changes & Cancellations:
If you need to cancel or reschedule, please notify us **at least 48 hours in advance** (Monday–Friday, 9am–5pm). This gives us time to offer that slot to another patient in need.

No-Show Fees:
Missing an appointment without proper notice affects everyone's care. The following fees will apply to missed appointments:

☐ **Sleep Study (In-Lab):** $250

☐ **Office Visit (Consults, Follow-ups):** $50

These fees are billed directly to you and are not covered by insurance.

We're here to support your sleep health journey, and we appreciate your help in making uNITE a place where people come first.

If you have questions about this policy or need assistance rescheduling, give us a call—we'd love to help.

Patient name: _____

_____ _____

Signature Patient or Responsible Party: Date:

_____ _____

Signature of Witness: Date:

Financial Policy

Patient Name: j

At uNITE, we're committed to delivering exceptional care—and that includes being upfront and honest about financial responsibilities.

Payment Expectations

We kindly ask that **all copayments, coinsurance, and unmet deductibles be paid at the time of service.** This helps us keep operations smooth, reduce billing delays, and focus on what matters most: your health.

Insurance & Coverage

While we're happy to bill your insurance as a courtesy, it's important to remember:

- Your insurance policy is a contract between you and your insurer.
- You are responsible for any portion not covered by insurance, including non-covered services, denied claims, or unmet deductibles.

Financial Responsibility

By receiving care at uNITE Sleep Institute, you agree to be financially responsible for all services provided. If your account becomes past due and is referred to a collection agency or legal counsel, **you will be responsible for all associated collection and legal fees** in addition to the balance owed.

Returned Checks

Checks returned for insufficient funds will incur a **$45 returned check fee.** If a check is returned a second time, the account may be referred to collections for recovery.

We're always here to support you. If you need help understanding your financial responsibility or want to set up a payment plan, don't hesitate to reach out. We believe that clear communication builds trust—and we're in this with you.

Signature Patient or Responsible Party

Date

HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I

I,_____, give my permission for _____to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II – Health Information

I would like to give the above healthcare organization permission to: (Tick as appropriate)

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or,

☐ Disclose my complete health record except for the following information

- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other (Specify): _____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal

☐ Hard copy

Section III – Reason for Disclosure

Please detail the reasons why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s)

Name: _____ Organization: _____

Address: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

_____

_____

_____

Section V – Duration of Authorization

This authorization to share my health information is valid: (Tick as appropriate)

☐ A) From _____ to _____

Or,

☐ B) All past, present, and future periods

Or,

☐ C) The date of the signature in section VI until the following event:

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____ Organization: _____

Address: _____

I understand that:

In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.

I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.

I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

_____ _____

Name of person completing this form: Signature of person completing this form:

Describe below how this person has legal authority to sign this form:

_____

_____

_____

_____

_____

_____

_____

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Consent for AI Audio Transcription

At **uNITE**, we are dedicated to providing safe, accurate, and compassionate care. To help our practitioners document your visit more accurately and efficiently, we may use **artificial intelligence (AI) technology to create a transcript from audio recordings** made during your appointment.

Purpose of AI Audio Transcription

- To assist your practitioner in creating complete and accurate medical documentation.
- To reduce the risk of errors and ensure your medical record reflects your care correctly.

How It Works

- With your permission, audio from your visit may be transcribed by a secure AI system.
- The **audio is deleted immediately after transcription** and is **not stored**.
- Only the transcript, which becomes part of your medical record, will be retained.

Privacy and Security

- Your privacy is protected. All transcription is performed in compliance with HIPAA and applicable privacy laws.
- Transcripts are only accessible to authorized staff involved in your care.
- No recordings or transcripts will ever be shared outside of **uNITE** without your written permission, unless required by law.

Your Rights

- Participation is voluntary. You may decline AI transcription without affecting your care.
- You may withdraw your consent at any time by notifying **uNITE** in writing.

Consent Statement

☐ I consent to the use of AI audio transcription for my visit at **uNITE** Sleep Institute. I understand the audio will be deleted immediately after transcription.

Patient Name: j _____

Signature: _____ Date: _____

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General Consent for Care and Treatment

TO OUR PATIENTS: You have the right to be informed about your condition and the medical, diagnostic, or therapeutic options available to you. This ensures you can make decisions about your care with a clear understanding of the benefits, risks, and alternatives.

At this point in your care, no specific treatment plan has been recommended. This consent form gives uNITE Sleep Institute permission to perform the evaluations and examinations needed to determine the most appropriate treatment for you.

Scope of Consent

By signing below, you are indicating that:

- You consent to reasonable and necessary medical examinations, testing, and treatment related to your condition and care at uNITE Sleep Institute.
- This consent is continuing in nature and remains effective after a diagnosis is made and treatment is recommended, unless you revoke it in writing.
- Your consent applies to care provided at this location or any affiliated uNITE Sleep Institute office.

You may discontinue services at any time.

Your Rights

- You have the right to discuss any test, treatment, or procedure with your provider, including its purpose, risks, and benefits.
- You are encouraged to ask questions and voice concerns about your care at any time.
- If additional testing, procedures, or interventions are recommended, you will be provided with specific information and asked to give separate written consent before they are performed.

Authorization

I voluntarily request that physicians, advanced practice providers (such as Nurse Practitioners or Physician Assistants), respiratory therapists, technologists, and other healthcare professionals at uNITE Sleep Institute provide reasonable and necessary examinations, testing, and treatment for the condition that brought me to seek care.

I certify that I have read and fully understand the above statements. I consent knowingly and voluntarily to receive care and treatment under these terms.

Patient Name: j _____ Signature: _____ Date: _____

Parent/Guardian (if applicable): _____ Witness/Staff Name: _____ Date: _____