Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P .C.

Sleep Lab: 2024-C Opitz Blvd., Woodbridge, Virginia 22191
Hours: 8:30 PM – 5:30 AM
Office: 703-497-0212 (9:00 a.m. – 5:00 p.m.)
Sleep Lab: 703-490-8002 (after 8:00 p.m.)
www.VPASleep.com

Your appointment has been scheduled in our sleep lab on _____.
You should arrive at 8:30 p.m. and leave the following morning no later than 5:30 a.m.

Please bring with you the following: photo ID, insurance card(s), insurance referral (if required), and prescription for the study, sleep questionnaire packet, and comfortable two-piece sleeping clothes. You may also wish to bring toiletries and any medications that you would normally take during the scheduled study time.

Please note that, when authorization is required, if we are unable to obtain prior insurance authorization for your study then we will have to cancel your study.

48 HOURS NOTICE IS REQUIRED FOR CANCELLATIONS OF ALL APPOINTMENTS BY CALLING (703) 497-0212. Otherwise, a $125.00 no-show fee will be charged to your account for missed appointments. This charge will not be covered by your insurance company.

If you have any questions, problems or special needs please call our office (703-497-0212) during our daytime business hours (i.e., Monday through Friday, 9:00 a.m. to 5:00 p.m.). If you have an emergency or need assistance after normal business hours or on the weekends, please call the sleep lab directly at 703-490-8002 after 8:00 p.m.

Concerning Your Sleep Study Results

Please make a follow-up appointment with Dr. Mortazavi, Dr. Goudarzi, or the ordering physician, to review the results and determine a treatment plan. Test results are usually available within five to ten business days.

Please be advised that the Sleep Disorders Center of Woodbridge does not give test results over the phone. These studies are complex and the physician will need to spend time explaining the results to you. In many cases, a treatment plan will also need to be developed. Sleep Disorders Center of Woodbridge is a testing facility. We do not order any treatment (CPAP, etc.) if you have not had a consultation with one of our doctors.

Instructions for your Sleep Study

1. Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply face or body cream/lotion.
2. You may have to wash your hair several times to remove the paste used during the study. (A fine tooth comb may be helpful)
3. Take your regular medications, unless otherwise instructed by your physician. Please bring any medications with you that you may need to use during your stay.
4. Limit fluids after 6 PM the evening of the study.
5. Do not drink any alcoholic beverages on the day of study.
6. Do not consume any chocolate or caffeinated beverages after 12:00 noon the day of the study.
7. Try to get a normal night's sleep the night before your study. Do not take naps during the day of the study.
8. You are required to sleep in nightclothes, (i.e., pajamas or shorts and T-shirts). Your nightclothes should be loose fitting and preferably, two-piece. Do not wear satin, nylon or silk pajamas due to the chemicals/pastes that are used.
9. Bedding is provided but you may bring your own pillow, blanket, etc.
10. Please feel free to bring a book or magazine to read if you have a little spare time.
11. If you have been scheduled for a daytime study the sleep center coordinator will give you specific instructions.

Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P .C.

Patient Demographics

Patient Name _____ Date of Birth _____

Height _____ Weight _____ Marital Status _____ Sex (circle): Male Female
Street Address _____
City/State/Zip Code _____
Home Phone # _____ Cell Phone # _____ Social Security # _____

Patient's Employer _____ Occupation _____ Phone # _____
Employment Street Address _____
City/State/Zip Code _____

Emergency Contact & Relationship_____ Phone # _____

Primary Insurance Provider Name _____
ID# _____ Group # _____
Policy Holder's Employer _____ Phone # _____
Policy Holder's Name _____ Date of Birth _____
Policy Holder's Relationship to Patient _____
Policy Holder's Social Security # _____
Policy Holder's Street Address _____
City/State/Zip Code _____

Secondary Insurance Provider Name _____
ID# _____ Group # _____
Policy Holder's Employer _____ Phone # _____
Policy Holder's Name _____ Date of Birth _____
Policy Holder's Relationship to Patient _____
Policy Holder's Social Security # _____
Policy Holder's Street Address _____
City/State/Zip Code _____

Referring Doctor	Primary Doctor	Doctor to Receive Copy
_____	_____	_____
Phone #: _____	Phone#: _____	Phone#: _____
Fax#: _____	Fax#: _____	Fax#: _____
Address: _____	Address: _____	Address _____
_____	_____	_____
_____	_____	_____

Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P .C.

Billing Policies

Virginia Pulmonary Associates, P.C. (VPA) will bill the patient's insurance company for services rendered. The patient is responsible for all charges not covered by the insurance company, such as deductibles, co-pays, and non-covered services.

VPA only files claims to insurance companies with which our doctors participate.

Returned Check Fee: In the event of a returned check, the patient will be responsible for paying a $35.00 returned check fee.

HMO Patients: VPA is a specialty medical practice. It is the patient's responsibility to obtain required referrals from the primary care physician prior to each visit.

By signing this policy, the patient authorizes:

- insurance payments to go directly to Virginia Pulmonary Associates, P.C. T/A Sleep Disorders Center of Woodbridge,
- the release of medical records to the insurance company if necessary, and
- their insurance company to release information to Virginia Pulmonary Associates, P.C.T/A Sleep Disorders Center of Woodbridge.

I (Patient/Parent/Guardian) certify that I understand and agree with the above policies and that the information I have given is correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____
Patient Name (Please Print): _____
Date: _____

Assignment of Benefits

I hereby assign Virginia Pulmonary Associates, P.C. (VPA) all medical and surgical benefits to which I am entitled, including benefits provided by Medicare, Private Insurance, and any other insurance plan(s).

I hereby authorize said assignee, VPA, to release all information necessary to secure payment for services rendered and products delivered, including appeals on my behalf to the Insurance Commissioner. I also authorize my insurance company to release any / all information to VPA that may be necessary to secure payment.

I understand that I am financially responsible for all charges. I certify that I have read, and fully understand, the above Assignment of Benefits.

Patient/Parent/Guardian Signature: _____
Patient Name (Please Print): _____
Date: _____

Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P .C.

Patient Questionnaire

Patient Name: _____Date: Sep 8, 2014

Briefly describe your primary complaint as it relates to sleep: _____
_____

Medical History

1. Please list all of your chronic medical history (e.g., diabetes, HTN, heart or lung disease, etc.):_____
_____
_____

2. Please describe your average caffeine and alcohol intake per day:
_____

3. List any family history related to sleep disorders such as sleep apnea, narcolepsy, nightmares, and night terrors, sleep walking, insomnia, and load snoring? If so, please explain:_____
_____
_____

Sleep History

4. Do you feel that you have insomnia? Yes_☐_ No _☑_
5. Do you feel that you get too little sleep? Yes_☐_ No _☑_
6. What time do you go to bed on weekdays? _____ Weekends? _____
7. How long does it take you to fall asleep? _____
8. How many hours of sleep do you get on an average night? _____
9. Do you take naps during the day? Yes_☐_ No _☑_
If yes, at what time and for how long? _____
10. Do you use caffeine or other stimulants to stay alert? If yes, explain.
_____
11. Do you have excessive daytime sleepiness? If so, explain.
_____
12. Do you experience dreams and / or nightmares? Yes_☐_ No _☑_
13. Do you have any unusual sleep behavior such as sleep talking, moaning, yelling, etc? Yes_☐_ No _☑_
14. Do your arms or legs bother you when resting or while falling asleep? Yes_☐_ No _☑_
15. Do you snore? Yes_☐_ No _☑_
16. Have you been told that you have pauses in your breathing during sleep? Yes_☐_ No _☑_
17. Do you have difficulty breathing while lying on your back? Yes_☐_ No _☑_
18. Do you wake up choking or gasping for air? Yes_☐_ No _☑_

Sleep Disorders Center of Woodbridge

Virginia Pulmonary Associates, P .C.

Patient Name _____ Date Sep 8, 2014

The Epworth Sleepiness Scale

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 try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

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

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g., theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when the circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Submit Print