RICHARD H KELLER, DDS, MPS
Craniofacial Pain and Sleep Center, PC

2627 Redwing Rd. #300
Fort Collins, CO 80526
970-484-0250

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

We have opted out of Medicare/Medicaid and we are out of network for all insurances. In most cases and as a courtesy, we can assist the patient in billing claims to the insurance company. This office cannot guarantee that the insurance company will reimburse patient 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. 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 the patient reimbursed 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, all major Credit Cards and CitiHeath 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 _____________

Secondary insurance filing is the member's responsibility

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. Richard Keller or staff.

I herby 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 Craniofacial Pain and Sleep Center physicians and/or staff.

X____ ____________________
Signature Date

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Patient Name: ____ **Date:**________________

SLEEP QUESTIONNAIRE

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

___ Allergies
___ Anemia
___ Arthritis
___ Asthma
___ Breathing problems
___ Chest Pain
___ Chronic Cough
____Creutzfeidlt Jakob disorder
___ Diabetes
___ Ear problems
___ Epilepsy
___ Excessive thirst
___ Excessive urination
___ Fainting spells
___ Glaucoma
___ Heart murmur
___ Heart trouble
___ Hepatitis A B or C
___ HIV
___ Kidney disease
___ Latex allergy
___ Liver disease
___ Low blood pressure
___ Malignancies
___ Neurological problems
___ Rheumatic fever
___ Sinus problems
___ Stroke
___ Thyroid disorders
___ Tonsillitis
___ Tuberculosis
___ Ulcers

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____________________
Asst.___________________

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

Situation		**Chance of Dozing**
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 Sale

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

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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 confidentially 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 review 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, medial 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: Brenda Neiry, Manager-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: 7.15.10

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF INFORMATION PRACTICES

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

____ ________________________________

Signature Date

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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

Regardless of insurance coverage, payment is due at time of service. As a courtesy, we will file commercial insurance for you. If services are a covered benefit, payments should be made directly from your insurance company to you. It has been explained to me that I am responsible for the entire professional fee, and my insurance company is responsible to me.

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 24hours in advance.

As a payment option, we accept Visa, MasterCard, and Discover.

_____IMPORTANT

Dr. Keller is NOT a Medicare or Medicaid or Tricare provider and, as such, is an "Opt-Out Provider". As a patient of Dr. Keller, you enter in to a private contract with our office whether or not you are a Medicare, Medicaid and/or any other insurance beneficiary. Insurance coverage is a contract between yourself, your employer, if employed, and your insurance company. All treatment provided in our office will be on the same basis as a non-insured patient, including the fee. Therefore, it is imperative that our office overhead not be increased because of unnecessary demands made by the insurance carrier or union. Our office is not a network provider for any insurance company. As long as you are able to choose your provider and there are benefits available, there should be some type of payment rendered to you directly.

____
SIGNED

____
DATE

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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 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. The Moses appliance is approved by the FDA (K093710) as a mandibular re-positioner for the treatment of snoring and sleep apnea.

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 regiment works about 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 can not masticate their food as well as before.

It is probable that these patients most likely had an underlying temporomandibular disorder (TMD). The Moses™, like most intraoral sleep appliances, is a muscle deprogrammer. 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.

The Moses™, 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 warrantees 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: _________________