Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

The Center for Sleep Disorders
94 Old Short Hills Road
Livingston, New Jersey 07039
Telephone (973) 322-9800 Fax (973) 322-9808

AASM 2021 ACCREDITED Facility Member

Dear Patient:

Thank you for choosing The Center for Sleep Disorders at Cooperman Barnabas Medical Center (CBMC).

Your sleep study appointment is scheduled for _____ at _____ AM/ PM

Please be advised all patients undergoing attended sleep studies must have routine Polymerase chain reaction (PCR) testing for SARS-CoV-2 completed within 72 hours prior to your scheduled appointment. Following testing, patients should self-quarantine, wear mask, practice social distancing, and inform our center of contact with COVID-19 positive patient(s) or ill symptoms until day of procedure.

Please fill out the enclosed questionnaire and bring at the time of your appointment.

For your convenience we have **FREE** parking available. Enclosed you will find a parking permit that is to be placed on your dashboard window where it is visible for security personnel on the day/ night of your scheduled sleep study.

Directions to Parking:

1. Once you've arrived to CBMC please follow signs to **"North Entrance"** as our Sleep Center is located towards the back of the building.
2. Then follow signs to Sleep Center.
3. Self-Park in the designated parking spaces near Parking Lot 4 & 5 labelled as **"Sleep Center/ Radiation Oncology Parking"** (blue and white sign) if you're here for overnight sleep study. If you are picking up the home sleep study unit, then valet park. Sleep Center entrance is by the wooden awning opposite Lot 4.

Entrance to Hospital/Sleep Center:

1. Please call Sleep Center Cell# 862-323-1953 upon arrival to the facility. If no response, then please try 973-322-9800 during weekdays and 973-322-5490 (security) on the weekends as alternative #s.
2. The sleep technologist will greet you at glass sliding door entrance and temperature screening will be performed upon entry to our facility.
3. All patients shall wear a face covering at all times while in our facility in the presence of other, in accordance with CDC recommendations for individual to cover their nose and mouth while around other people in public settings. Vented masks are not accepted. If you do not have one, then one will be provided by our staff member.
4. All patients will perform proper hand hygiene (with alcohol hand rub or hand soap) immediately upon entry to facility and as needed during the course of your stay.
5. Practice of social distancing of 6 feet part will be maintained
6. The sleep technologist will escort you to the Sleep Center.

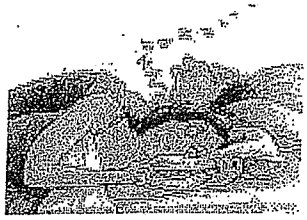
Please be advised you will incur a $50.00 cancellation fee if you fail to notify the Sleep Center within 48hours of your appointment.

Should you have any questions or wish for further information, please contact us at (973) 322-9800, Monday through Friday, 8:00 a.m. to 4:00 p.m. All voicemails will be returned within same or next business day.

Sincerely,
The Staff of Center for Sleep Disorder

Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

* *PREPARING FOR YOUR VISIT* *



In order for your appointment to proceed smoothly, it is important that you follow the guidelines below:

- Please arrive to the Sleep Center at your scheduled time. Bring a legal form of ID (i.e. driver's license, passport, etc.), insurance card(s), medication list, COVID vaccination card (if applicable) and your filled out questionnaire. If you're running late, please call 973-322-9805 to notify us.
- **All cancellations must be made within 48 hours prior to appointment.** If you are ill, develop an acute illness, or upper respiratory infections (such as nasal congestion, common cold, etc.) prior to your scheduled appointment, please contact your doctor or Sleep Center to see if test should be rescheduled. Please be advised a cancellation fee of $50.00 can incur if you fail to notify us of your cancellation within 48 hours.
- If you have any special needs and/or require assistance or accommodations (i.e. wheelchair, recliner, dietary needs, etc.), please inform Sleep Center staff in advance so that necessary arrangements are made prior to your scheduled appointment.
- Daily medication(s) should be taken the same as usual unless otherwise directed by your physician. Should you have any questions regarding your medication(s), please talk to your doctor before your appointment as the Sleep Center staff cannot answer any medication related questions. Please be advised our staff **CAN NOT** give out any medication. If your physician has prescribed a sleeping pill, please bring this with you and notify your sleep technologist when taking medication.
- Please **remove or do not** apply colored nail polish to finger nails on the day of sleep study. **Do not wear artificial nails or extenders** (i.e. acrylics, tips, appliqués, crystals, gels, wraps or any additional items) to the nail surface.
- Avoid stimulants such as caffeinated products (i.e. coffee, tea, soda, and chocolates), alcohol, and nicotine during the day of your study especially after 2-3pm onwards.
- **DO NOT** nap or get up late on the day of your scheduled sleep study. If the patient is a child, please refrain from late afternoon or evening naps on the day of your test.
- Upon arrival to the sleep center, expect the following (***Your appointment is 30minutes to an hour***):
  - A short introductory video explaining the home sleep study procedure, what sleep apnea is and treatment option(s) [continuous positive airway pressure (CPAP)], and what the technologist's responsibilities are. Should you have any further questions or concerns, please consult your sleep technologist. Please be advised our technologist cannot disclose your test results. You will need to schedule a follow up appointment with your referring doctor to discuss your test results. Results usually take 1-2 weeks.
  - There will be additional paper work that needs to be filled out prior to and after your study. It is very important that you take the time to **fill out all the information completely** in your questionnaire including the packet you received through the mail/ email. If you did not receive the packet through the mail or forgot the packet at home, please inform staff on duty to give you a new packet at the time of arrival.
- You may encounter additional waiting time while your technologist is preparing your home sleep study. **Please be patient.**
- **Please try to be in bed by no later than 11:00pm and awaken by 6:00am to 7:00am.** This is to ensure that adequate data is acquired so that proper & effective treatment can be achieved. If you are a night shift worker or have an earlier or later bed time/ wake up time, please notify the Sleep Center in advance so special arrangements may be made to accommodate your needs.

- Please be advised once study is started, our protocol is **lights out and all electronic items must be completely turned off** (i.e. television, cell phone, laptop, tablets, iPod, etc.) as this interferes with our sleep equipment and signals. We try to practice and adhere to good sleep hygiene habits conducive to sleep.

NOTE:

- **For individuals with special needs or require assistance, a family member or personal assistant *MUST* accompany patient as Sleep Center does not provide medical care outside the compass of the Sleep Disorders testing. Our technologists are not trained for this.**
- **Please keep in mind you *MUST* return the home sleep test device by 10:00am the following day to the Sleep Center.**

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The Center for Sleep Disorders

SLEEP CENTER PARKING PERMIT

DATE: _____

PLEASE PLACE THIS CARD ON YOUR DASHBOARD, ON THE DRIVER'S SIDE ON THE DATE OF YOUR TEST.

For any questions, please call (973) 322-9800

PB00496 (5/22)

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THE CENTER FOR SLEEP DISORDERS

Adult-New Patient Questionnaire

Please complete this questionnaire and bring it with you to your sleep study. Answer all the questions as carefully and completely as possible. If not applicable, please write N/A. This information will be used to help make a diagnosis and treatment plan for sleep disorders. All information will be kept strictly confidential.

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Neck/ Collar Size: _____

What time do you go to bed on workdays?	____:____ AM/PM
What time do you go to bed on days off?	____:____ AM/PM
What time do you get up on workdays?	____:____ AM/PM
What time do you get up on days off?	____:____ AM/PM
How much sleep do you think you need per night?	_____ Hour(s)
What shift do you work? (circle those that apply)	DAY EVENING NIGHT
How long does it take you to fall asleep?	____ Hour(s) ____ Minute(s)
Do you sleep with a partner?	YES / NO

While lying awake in bed, do you...

Have thoughts racing through your mind?	YES / NO
Experience uncomfortable sensations in your legs?	YES / NO
Have inability to keep your legs still?	YES / NO
Experience pain or physical discomfort?	YES / NO
Worry about getting a good night's sleep?	YES / NO

Once asleep, do you...

Consider yourself a light or restless sleeper?	YES / NO
Wake up during the night?	YES / NO
If yes, how many times? _____ *Time(s)*	
What do you do when awakened? _____	
Do you snore?	YES / NO
Do you wake up too early and are unable to go back to sleep?	YES / NO
Have you ever wet the bed as an adult?	YES / NO
Do you talk in your sleep?	YES / NO
Do you grind your teeth?	YES / NO
Have you ever awakened with shortness of breath, or a choking sensation?	YES / NO
If yes, describe: _____	
Has anyone observed pauses in your breathing while you were asleep?	YES / NO

Patient's Name:
MR#:
PA#:
Affix Patient Label

Do you experience heartburn at night?	YES / NO
Do you kick your legs while you are asleep?	YES / NO

In the morning, do you...

Feel drowsy and un-refreshed?	YES / NO
Wake up with dry mouth?	YES / NO
Do you wake up with a headache?	YES / NO
If yes, describe _____	
How much time do you spend in bed after waking up in the morning?	
Do you sleep better when you are away from home?	YES / NO
Are you sleepy during the day?	YES / NO
How long have you experienced daytime sleepiness?	

During the past 6 months...

Have you dozed off during the day?	YES / NO
Is your work affected by your sleepiness?	YES / NO
Have you ever left a job because of daytime sleepiness?	YES / NO
Have you fallen asleep at inappropriate or embarrassing times?	YES / NO
Have you fallen asleep while driving?	YES / NO
Do you feel tired and exhausted during the day?	YES / NO

Do you take naps during the day if you are able to?	YES / NO
If yes: How many times per day? _____ *Time(s)* *How long do your naps last?* _____ *Are your naps refreshing?* YES / NO *Do you dream during naps?* YES / NO	
Do you have problems with your memory?	YES / NO
Have you been previously diagnosed with Narcolepsy?	YES / NO
Have you ever felt paralyzed or unable to move while waking or falling asleep?	YES / NO
Have you ever had hallucinations while falling asleep?	YES / NO
Do you have frequent nightmares?	YES / NO
Have you ever felt unable to talk or move upon awakening out of sleep?	YES / NO
Do you feel anxious or depressed?	YES / NO
Have you ever been under the care of a counselor, psychologist or psychiatrist?	YES / NO

Patient's Name:
MR#:
PA#:
Affix Patient Label

Have you ever been given medication for a psychological or psychiatric problem?	YES / NO
If yes, please list: _____	
Have you taken medication to help you sleep?	YES / NO
If yes, please list: _____	
List the amounts of caffeine you consumes daily: _____ glasses of soda _____ cups of coffee/tea _____ bars of chocolate _____ other caffeinated beverages	
Alcohol: [ ] Never [ ] No longer drinks [ ] Drinks [ ] Daily [ ] Weekends [ ] Other _____	
Smoking: [ ] Never [ ] Yes [ ] No longer	
Drug Use: [ ] Never [ ] Yes [ ] No longer	

Do you have allergies? Please indicate and explain below:

Latex? YES / NO **Tape?** YES / NO **Alcohol?** YES / NO

Foods? YES / NO _____

Environmental? YES / NO _____

Medication? YES / NO _____

Other? YES / NO _____

List below any medications you take currently (include vitamins, over the counter medications, herbals, aspirin, etc.). If none, please write "Not Applicable (N/A)":

	Medication	Dosage	Time Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Thank you for your cooperation. All information will be kept strictly confidential.

PATIENT SIGNATURE _____ DATE _____

CBMC 201 5-14-2022

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Patient's Name:
MR#:
PA#:
Affix Patient Label

THE CENTER FOR SLEEP DISORDERS

THE EPWORTH SLEEPINESS SCALE

- In the situations listed below, how likely are you to doze off or fall asleep in contrast to just feeling tired?
- This refers to your usual way of life in recent times.
- 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
1. Watching television	
2. Sitting and reading	
3. Sitting inactive in a public place (theater, meeting, etc.)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch without alcohol	
8. In a car, while stopped for a few minutes in traffic while driving	

TOTAL: _____

Cooperman Barnabas Medical Center

RWJBarnabas HEALTH

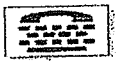
Pt. Name: Os Acct. #: MR#:

COMMUNICATION ASSESSMENT

In order to assure that the services that are provided to you (or to the patient that you are legally responsible for) are not compromised by ineffective communication, we ask that you complete this form so that we can assess your communication needs and preferences. Kindly check each appropriate item.

☐ I have no special communication needs

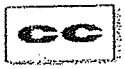
1. Deaf and Hard of Hearing



☐ I require the use of TDD/TTY

☐ I require the use of an amplified telephone receiver

☐ I require a closed caption television



☐ I prefer written notes for *brief* communication
☐ I prefer written notes for *all* communication

☐ I prefer to lip-read and speak for myself for *brief* communications
☐ I prefer to lip-read and speak for myself for *all* communications

☐ I require a qualified sign language interpreter (at no cost to me)

☐ Other (please specify) _____

2. Visually Impaired/Blind

☐ I require assistance with printed materials. ☐ Other (please specify) _____

3. Non-English Speaking

☐ I require a translator in my language for communication. My language is _____.

4. Special Needs Assistance For special needs assistance, contact the Bed Management department at 973-322-9874 or Nursing Administration. For TDD/TTY contact the Operator.

☐ I have read this form or have had it read to me.

_____ Date/Time: _____

Signature of Patient or person authorized to sign for patient

Relationship to Patient: _____

Patient is unable to sign because _____

_____ _____

Interpreter signature, if applicable Registrar electronic signature

Refusal of Services Offered

☐ Patient declined sign language interpreter ☐ Patient declined other auxiliary aids and services offered

Patient: _____ Date/Time: _____

Witness: _____ _____

Electronic Signature

A copy of the Facility's written Administrative Policy and Procedure is available upon request at no charge.

Please check here if you want a copy of this policy ☐.

Cooperman Barnabas Medical Center

RWJBarnabas HEALTH

GENERAL & FINANCIAL CONSENT
INPATIENT, OUTPATIENT & EMERGENCY DEPARTMENT

Pt. Name:

MR#: Pt#:

Birth: Sex:

1. CONSENT TO CARE: I request and authorize the Hospital named above(the "Hospital") and its employees, attending physicians, such associates, assistants and/or residents as may be selected by the said physician(s), and all the persons caring for me, and to provide such medical care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgment of the above persons deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that it may be necessary for my healthcare providers to take photographs, film, and record and/or take other like images for medical, educational and other continuity of care purposes. I understand that the Hospital is a teaching hospital, medical students, interns and/or residents may participate in my care and treatment I understand that no guarantees have been made to me about the outcome of this care.

   In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not. limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me, the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.

   Many conditions require multiple visits, services and/or sessions as part of a course of treatment. I understand that my consent to treatment today may include consent to a course of treatment, and I will not necessarily need to sign a new consent for each visit as part of certain ongoing treatment. In the event that there is a change to my course of ongoing treatment, I understand that I may be required to sign a new consent form. Ongoing treatment may include, but is not necessarily limited to, radiation, respiratory, physical and occupational therapies, speech pathology, kidney dialysis, cardiac rehabilitation, oncology services and behavioral health services. If, during a period of recurring visits as part of a course of treatment, any of my registration information changes (e.g., address, phone, employment, insurance, guarantor, etc.), I will provide notice of the change to the Hospital department where I originally registered.

2. MATERNITY DIVISION: If I am admitted to have a baby, this consent shall also apply to the admission and Hospital treatment of the baby (ies) who is/are delivered by me during the hospitalization.

3. PERSONAL VALUABLES: I have been informed to send all valuables home. I understand that if I choose to keep any valuables at the hospital not deposited for safekeeping, the Hospital will be released from all responsibilities in the event of the loss of my personal property. I hereby certify that I have been advised and fully understand that the Hospital and its staff are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I understand that I was told to deposit my valuables for safekeeping with the Hospital in accordance with the Hospital's policy and procedures.

4. RELEASE OF INFORMATION: I understand that my patient information is kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. The Hospital may access electronic information about me from pharmacies I use, including prescriptions to treat AIDS/HIV, mental health issues, substance abuse and sexually transmitted diseases, if applicable. The pharmacy information will become part of my hospital medical record. I understand that if I do not wish the Hospital to access my pharmacy information, I must submit a written request to the Hospital's Privacy Officer. The Hospital also participates in electronic health information exchanges (HIEs) with various other health care providers. Additionally, the Hospital works in partnership with other health care providers, scientists, and health care databases/clinical data repositories for research purposes, including the clinical research data warehouses with those whom the Hospital has affiliations ("Research

Partners"). I authorize the Hospital and the HIEs with which it participates to share my health information through the HIE networks, for-purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information and with Research Partners. I understand and agree that the information about me that may be shared and accessed through the HIEs and with other health care providers, and shared with Research Partners may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, Genetic Information (as defined below) and genetic test results, use of alcohol and other substances and other sensitive categories of my health information. Genetic Information may include information about my genetic tests, the genetic tests of family members, information about any diseases or disorders in myself or a family member, and requests for, or receipt of, genetic services, genetic counseling, genetic education or participation in a clinical trial which includes genetic services. This information could include information about genes, gene products, or inherited characteristics from myself or a family member, and the genetic information of a fetus or embryo, as applicable. I understand that I have the right to "opt-out" of having my information shared through HIEs and Research Partners, and instructions on how to do that can be found in the Notice of Privacy Practices, or may be requested from the Hospital's Privacy Officer.

If I have received treatment for substance abuse or mental health services, I authorize the Hospital to release my information to clinical providers, including medical providers, for my treatment.

The Hospital may seek, release and verify all or part of my medical and/or financial records, including if applicable, information about my substance abuse treatment, to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to me, the hospital, my family member, or my employer, for all or part of the Hospital's charges.

5. CELL PHONE, TEXTING, EMAIL AND OTHER CONTACT: I grant permission and consent to the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/or regarding funds owed by me, (3) to send me text messages to cell phone numbers or emails using any email addresses I provide, and (4) to use prerecorded/artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account. I have checked all demographic information (attached) and it is accurate. I can revoke my permission to contact me by cell or email at any time by giving written notice to RWJBarnabas Health, Customer Service Department, Attn: Director, A/R Services, P.O. Box 903, Oceanport, NJ 07757.

6. DISPOSAL OF SPECIMENS: I authorize the Hospital to dispose of all specimens and tissues taken for laboratory or pathology examination as well as all equipment and devices removed from my body (such as artificial joints, pacemakers, etc.).

7. FINANCIAL AGREEMENT: For and in consideration of services rendered, I agree to make prompt payment to the Hospital when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, co-payments, and/or co-insurance. I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services. I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's ability to pay. If the Hospital, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or are non-covered services; I must pay for those services deemed to be a patient responsibility.

8. APPEALS: By my signature below, I hereby consent to the hospital, acting on my behalf, discussing with or appealing to my government or commercial insurance, its medical director and/or is physician designee, or otherwise taking actions with respect to any utilization management, payment obligatory or other determination made concerning the professional medical services provided or to be provided to me by the hospital, professional staff, in accordance with my insurances informal (stage I) and formal (stage II) appeals process and applicable law. I consent to the hospital pursuing such appeals on my behalf; however, I recognize that the hospital has no obligation to pursue such appeals.

9. AUTHORIZATION OF PAYMENT OF INSURANCE BENEFITS: In consideration of the medical and/or physician services furnished to me by the Hospital and/or its authorized representatives, I hereby assign, authorize and request payment directly to the Hospital (or if applicable, to the physician or organization furnishing physician services to me at the Hospital) of all monies, rights, title and interest and/or benefits to which I may be entitled from government agencies, health insurance carriers, Medigap policy, self-funded employer or welfare benefit plans, or others who are financially liable for my medical care and treatment to cover the costs of care and treatment. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered, including, if applicable, information and medical records about my substance abuse treatment.

10. MEDICARE AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that direct payment or authorized benefits be made on my behalf. I assign benefits payable for physicians' services to the physician or organization furnishing the services or authorize such a physician or organization to submit a claim to Medicare for payment.

11. DESIGNATED CAREGIVER: I understand I will have the opportunity to designate at least one (1) caregiver after I have entered the Hospital and prior to my discharge. If I do choose to designate a caregiver, I understand that the Hospital will request my written consent to release my medical information to the designated caregiver in accordance with privacy laws, including HIPAA. I also understand that if I do not provide this written consent, the Hospital will not give my caregiver notice of my discharge plan.

12. ADVANCE DIRECTIVE:
I have an Advance Directive/Living Will/Health Care Agent/Psychiatric Advance Directive ☐ Yes ☐ No ☐ Unknown
I have provided the Hospital with copy(ies) ☐ Yes ☐ No

ACKNOWLEDGEMENTS:

- I acknowledge receipt of the Hospital's Privacy Notice.
- I acknowledge receipt of the Patient's Bill of Rights
- I have been provided with the notice of Financial Assistance Program information

GENERAL AND FINANCIAL CONSENT SIGNATURE:

Patient Signature / Authorized Representative	Print Name and Relationship/Authority to Sign if Patient is not Signing
Date / Time	Employee Initials
Reason that the Patient is unable to sign:	Witness:

New Jersey Department of Banking and Insurance
Consent to Representation in Appeals of Utilization Management Determinations and Authorization for Release of Medical Records in UM Appeals and Independent Arbitration of Claims

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey.
Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case.
Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours.
Stage 3: your case will be reviewed through the independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At stage 3, the health care provider will share your personal and medical information with DOBI, the IURO and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

Independent Arbitration of Claims

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

Consent to Representation in UM Appeals and Authorization to Release of Information in UM Appeals and Arbitration of Claims

I, _____, by marking ☑ and signing below, agree to:

☐ Representation by *Cooperman Barnabas Medical Center* in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2s-11, and release of personal health information to DOBI, it's contractors for the Independent Health Care Appeals Program and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ Release of personal health information to DOBI, it's contractors for the Independent Claims Arbitration Program and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins ID#: _____ Date: _____

Relationship to patient: ☐ I am the patient ☐ I am the personal representative (provide contact information on back)

* If the patient is a minor or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobiihcaparb 07/06

New Jersey Department of Banking and Insurance
Notice of Revocation of Consent to Representation in Appeals of Utilization Management Determinations and of Authorization to Release of Medical Records

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care - Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by *Cooperman Barnabas Medical Center* and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobiihcaparb 07/06

Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

PATIENT ACKNOWLEDGEMENT REGARDING PHYSICIAN SERVICES

Patient Name: _____

MRUN: _____ Account #: _____

The Courts in New Jersey have determined it important for patients to know the relationship of physicians to the hospitals in which they practice. As is common practice in the hospital industry, most physicians who render care at Bnnodq ` mBarnabas Medical Center are independent contractors or private attending physicians who are odq hsdc to treat their patients at the Medical Center.

These doctors are not employed by Bnnodq ` mBarnabas Medical Center, and may include, without limitation, xnt qattending physicians, physicians in the hospital based departments of Radiology, Anesthesiology, Radiation Oncology, Emergency Medicine, and physicians in other departments called upon to interpret certain tests. These physicians are providing professional physician services as private practitioners and not on behalf of the hospital.

Any particular preference you may have regarding your choice of physicians should be expressed prior to receiving care. You may also choose to reject care being offered by particular physicians. Should you opt to reject care or the services of particular physicians, you should ask to speak to a hospital representative.

A separate bill for professional physician services will be sent directly to you from these independent providers. In addition, these doctors may or may not be participating providers in your health plan. You should direct any insurance coverage issues regarding physician services to your insurance company.

Acknowledged by:

_____ _____

Patient Signature/Authorized Representative Date/Time

_____

The Patient is unable to sign because:

If this authorization is signed by a patient's representative please complete the following:

_____

Printed name of the patient's representative

_____

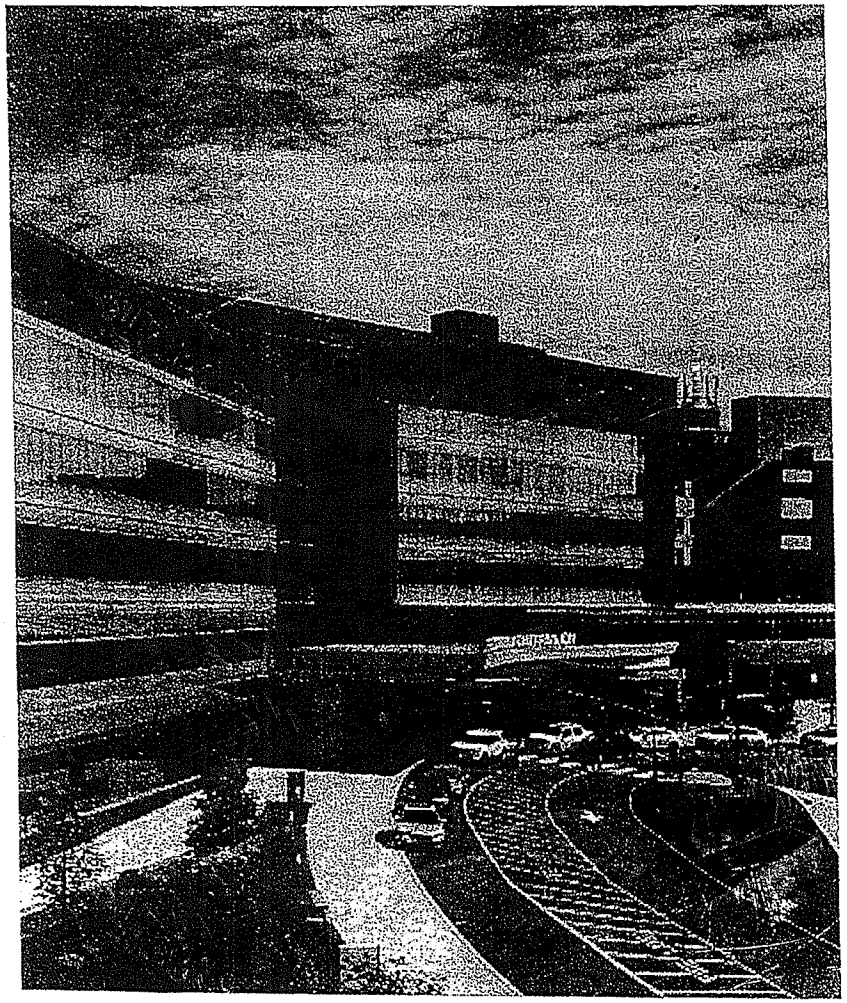
Relationship to the patient

Describe the representative's authority to act for the patient:

_____

Pre-Arrival Guide

Cooperman Barnabas Medical Center



Directions

From Garden State Parkway (North and South):

- Take exit 145 The Oranges–Route 280 West
- From 280 West, take exit 6A Laurel Avenue
- From the exit, continue straight on Laurel Avenue (which eventually becomes Shrewsbury Drive, then East Cedar)
- Cooperman Barnabas is 3.3 miles from Exit 6A, on the right

From New Jersey Turnpike (North and South):

- Take exit 15W to Route 280 West. Take exit 6A Laurel Avenue, and follow the directions above
- Alternately, individuals may wish to exit at Route 78 West, then follow directions as below

From Route 287 (North and South):

- Exit at Route10
- Follow east to Livingston traffic circle and follow blue and white hospital signs to the Medical Center

From Route 80 (East):

- Take exit 6A Laurel Avenue, and follow the directions above

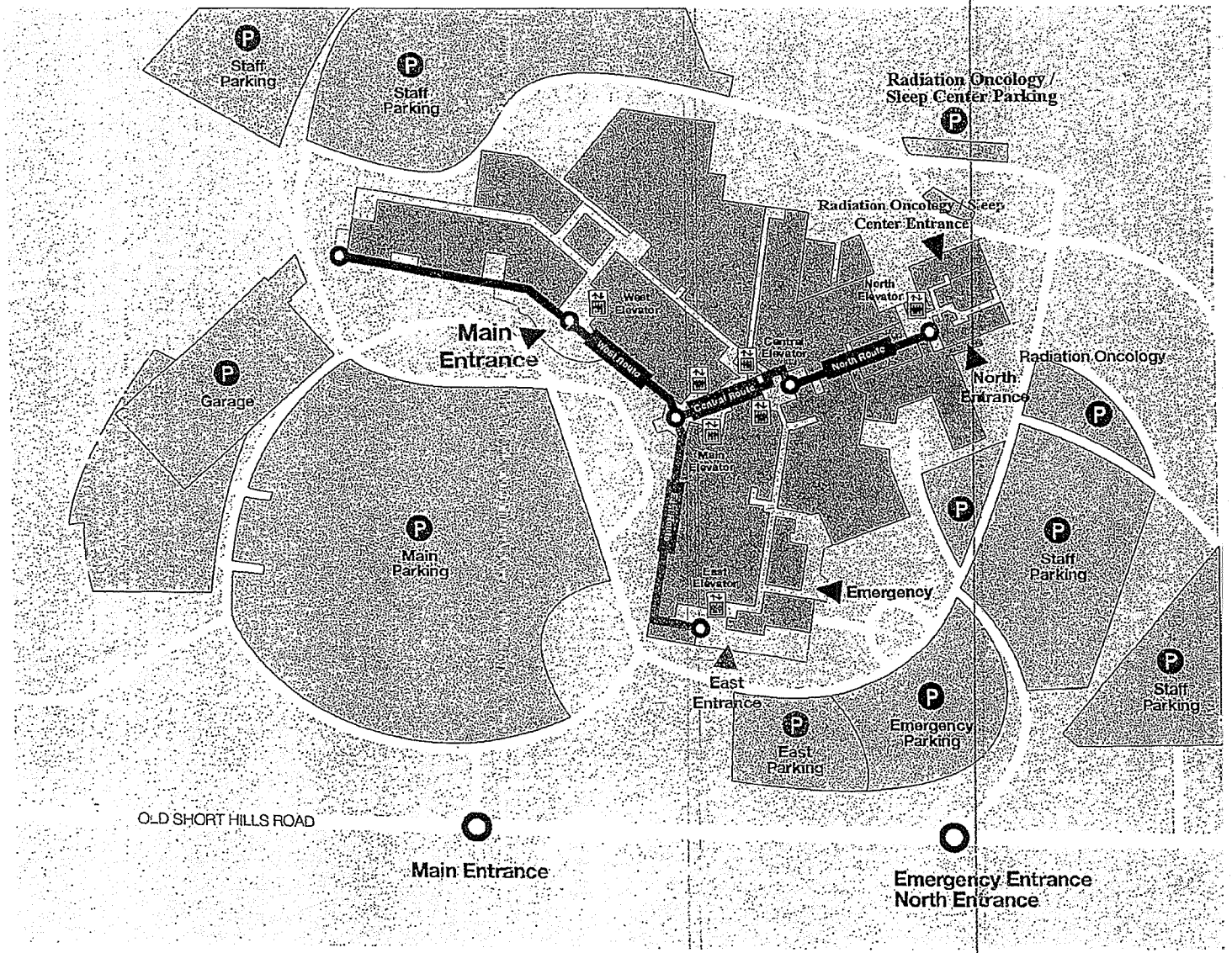
From Route 78 (East):

- Exit at Route 24 West
- Continue to JFK Parkway, following signs to Livingston
- Turn right at the light onto South Orange Avenue
- Turn left at second traffic light onto Old Short Hills Road
- Cooperman Barnabas will be on your left at the next traffic light

From Route 78 (West):

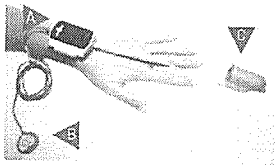
- Exit near the Short Hills Mall onto Route 24 West
- Take exit 7C to JFK Parkway, following signs to Livingston
- Turn right at the light onto South Orange Avenue. Turn left at second traffic light onto Old Short Hills Road
- Cooperman Barnabas will be on your left at the next traffic light

Cooperman Barnabas Medical Center | RWJBarnabas HEALTH


Staff Parking
Staff Parking
Radiation Oncology / Sleep Center Parking
Radiation Oncology / Sleep Center Entrance
North Elevator
West Elevator
Main Entrance
West Route
Central Elevator
North Route
Radiation Oncology North Entrance
Garage
Central Route
Main Elevator
Main Parking
East Elevator
Emergency
Staff Parking
East Entrance
Staff Parking
Emergency Parking
East Parking
OLD SHORT HILLS ROAD
Main Entrance
Emergency Entrance
North Entrance

WatchPAT 300 - Step by Step Guide

This guide is to be used after your practitioner has showed you how to use the WatchPAT device.

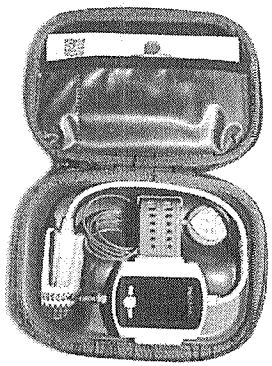


A - Power Button
B - Respiratory Effort Snoring and Body Position sensor (RESBP)
C - Finger Probe

Before applying the WatchPAT:

- It is recommended to apply the WatchPAT device to your non-dominant hand.
- Probe can be worn on any finger, except the thumb. If you have large fingers, the pinky is recommended.
- Before use, remove tight clothes, rings, watches and other jewelry.
- Remove nail polish and artificial nails from the test finger and make sure the fingernail is cut short.

Note: Once you have turned on the WatchPAT device, it cannot be turned off.
Apply the device and turn it on only when you are ready to sleep.
Note: Adult supervision may be required to apply the device.
Note: Images in the demonstrated guide are for the left hand; similar process can be applied for the right hand.

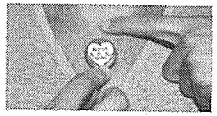


The carrying case contains:

- This reference guide
- Device with Finger Probe
- Respiratory Effort Snoring and Body Position sensor (RESBP)

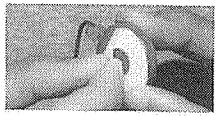
Help Desk Number 1-888-748-2627

Step 1 - Applying the Respiratory Effort Snoring and Body Position sensor (RESBP)

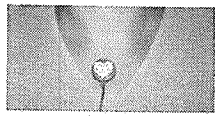


1a. For men: trim thick chest hair, if needed.

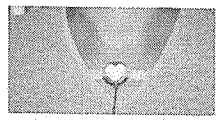
1b. Take the RESBP Sensor through the sleeve of your night shirt up to the neck opening.



1c. Peel the white paper from the back of the sensor.

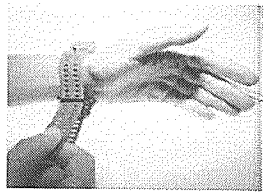


1d. Stick the sensor to the center of your upper chest bone, just below the front of neck. Make sure the image on the RESBP sensor is upward facing.



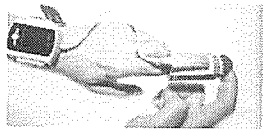
1e. Secure the RESBP sensor with additional medical tape.

Step 2 - Applying the WatchPAT Device

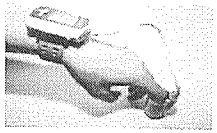


2a. Strap the device to your non-dominant hand.
2b. Close wrist strap (not too tightly).

Step 3 - Applying the Finger Probe



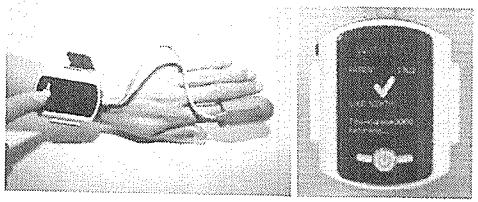
3a. Probe can be worn on any finger, except the thumb. If you have large fingers, the pinky is recommended.
3b. Insert the finger into the probe until you feel the end. The sticker marked TOP should be on the top of your finger (Above the nail).



3c. Press the tip of the probe against a hard surface (i.e. table, leg.)
3d. Pull and remove the TOP tab completely out of the probe.

✦ Step 4 - Turning ON the Device

Note: The device should only be turned on when you are ready to go to sleep.



4a. Press firmly on the Power button until the display lights up. Next screen "Please wait Testing..." After a few seconds "GOOD NIGHT!!!" ✔ message will appear. The display will turn OFF after a short period.

4b. In the case there is a problem, "TEST ABORTED" ✖ will appear, call help desk 1-888-748-2627

You are now ready to go to sleep.

4c. In the case your finger is not inside the probe, an error appears instructing you to insert the finger. Wait till the device turns off, insert finger and try again.

✦ Step 5 - During the night

- Anytime you press on the button, the display will light up for a minute.
- If you need to get up during the night, do not remove the device or sensors.
- Do not press any buttons if you need to get up during the night.
- If using the bathroom, do not get the WatchPAT wet.
- Should you encounter unbearable discomfort, remove the device and call the help desk.

✦ Step 6 - Next Morning

When you wake up:

6a. Device will turn off automatically. There is no OFF button.

6b. Remove the finger probe and the RESBP sensor

6c. Take off from your wrist.

6d. Insert all parts back into the carrying case

⚠ **Important Notes**

- Do not attempt to connect or disconnect any part of the unit.
- Do not try to introduce any foreign object into the unit.
- Do not try to connect the WatchPAT to an electrical supply or other device, machine or computer.
- Do not, under any circumstances, attempt to fix a problem by yourself.

Questions?

Call our Help Desk Number

1-888-748-2627

itamar medical | Health Being Made Simple

www.itamar-medical.com | infousa@itamar-medical.com

Worldwide:

Itamar Medical Ltd.

9 Halamish St., P.O.Box 3579

Caesarea Ind. Park 3088900, Israel

Tel + 972 4 617 7000

USA:

Itamar Medical Inc.

3290 Cumberland Club Drive, Suite 100

Atlanta, Georgia 30339, USA

Tel 1 888 748 2627

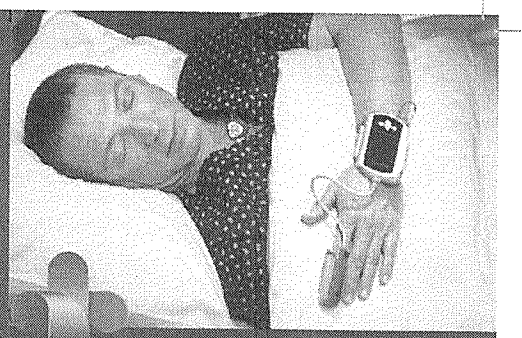
EC REP **Arazy Group GmbH**

The Square 12, Am Flughafen,

60549 Frankfurt am Main,

Germany

Caution: Federal law restricts this device to sale by or on the order of a licensed healthcare practitioner.



Step by Step Guide

WatchPAT™

Home Sleep Test

For an instructional video go to:
www.watchpat-howtouse.com

itamar medical

Cooperman Barnabas Medical Center | RWJBarnabas HEALTH

Patient's Name:
MR#:
PA#:
Affix Patient Label

MEDICAL EQUIPMENT FOR HOME USE

You, _____ (hereinafter, "You"), are receiving the _____ unit ("Equipment")/ Serial#_____ for your personal use at home. This Equipment is being provided to you subject to the following terms and conditions:

You will use the Equipment as instructed.

You shall return the Equipment to Cooperman Barnabas Medical Center in the condition that you are receiving it with all parts and in the packaging that you received.

You assume and shall bear the entire risk of loss, theft, destruction, or damage of or to any part of the Equipment ("loss or damage") from any cause whatsoever, whether or not covered by insurance, and no such loss shall release you of your obligation under this agreement in the event of loss or damage. You, at the sole option of Cooperman Barnabas Medical Center, shall pay for damages incurred to Equipment, which are not covered in manufacturer's warranty policy. In the event of loss, theft, or destruction during lease, you will be responsible for the total cost of the unit.

You shall not (a) assign, transfer, pledge, or otherwise dispose of this lease, the Equipment, or any interest therein or (b) sublet or lend the equipment or permit it to be used by anyone other than you, without Cooperman Barnabas Medical Center's prior written consent.

_____ _____
Participant Date

_____ _____
Witness Date