# Powell Dental Sleep Solutions

**Dba Powell Dental Group, LLC**
**Shelley D. Shults, RN, DDS & Associates**
**39 Clairedan Drive**
**Powell, OH 43065**
**614.436.4433/614.396.9310/614.436.6055 fax**

## PATIENT INFORMATION

Patient Name: _____ Preferred Name: _____
Birthdate: _____ SS# _____ Driver's License #: _____
Sex: Male ☐ Female ☐
Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Employed: ☐ Full Time ☐ Part Time ☐ Not Employed
Employer: _____ Occupation: _____
Employer Address: _____
Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable
School Name: _____ School City/State: _____
Emergency Contact Name: _____ Phone: _____ Relation: _____
Who May We Thank for Referring You to Our Office: _____

## FINANCIAL INFORMATION

(if same as patient, please check here _____and skip to next section)
Person Financially Responsible for Account: _____ Relation to Patient: _____
Birthdate: _____ SS#: _____ Driver's License #:_____ Sex: Male ☐ Female ☐
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Employer Name: _____ Email Address: _____

## INSURANCE INFORMATION

**Primary Dental / Primary Medical Insurance (please circle one)**
Insured Name: _____ Relation to Patient: _____
Birthdate: _____ SS#: _____ Subscriber ID #:_____
Employer: _____ Occupation: _____
Employer Address: _____
Insurance Company: _____ Ins. Co. Phone #:_____ Group #: _____
**Secondary Dental / Secondary Medical Insurance (please circle one)**
Insured Name: _____ Relation to Patient: _____
Birthdate: _____ Subscriber SS#: _____ Subscriber ID #:_____
Employer: _____ Occupation: _____
Employer Address: _____
Insurance Company: _____ Ins. Co. Phone #:_____ Group #: _____

***By Signing Below, I verify the information provided is accurate to the best of my knowledge.***

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Patient Name** | **Name of Responsible Party** | **Signature of Responsible Party** | **Date** |

## DENTAL HISTORY

Dentist: _____City, State: _____Date of Last Visit: _____ Date of Last X-rays: _____

**Please check all that apply:**

□ Missing Teeth □ Loose Teeth or Broken Teeth/Fillings □ Joint Clicking / Popping / Joint Pain □ Tooth Pain
□ Dry Mouth □ Current/Past Orthodontic Treatment □ Periodontal Disease □ Periodontal (gum) surgery
□ Wisdom Teeth Extracted
□ Do you wear dentures or partial dentures? Yes / No
□ Are you planning on having any dental implants placed in the future? Yes / No
□ Is there any dental treatment that you have not completed with your dentist? Yes / No\
□ Any other dental concerns? _____

## MEDICAL HISTORY

Primary Care Physician's Name: _____ Date of Last Visit: _____Phone Number: _____
Sleep Medicine Physician's Name: _____ Sleep Medicine Physician's Phone Number: _____
Date Last Seen: _____
Was CPAP Prescribed: Yes / No Are you using it? Yes / No Was oral appliance discussed? Yes / No
If you are currently using CPAP, how long have you used it? _____ Water Pressure: _____
If you have previously used CPAP, when did you use it? _____
If you have discontinued using CPAP, why? _____
Have you worn an oral appliance before? Yes / No For sleep apnea? Yes / No For grinding teeth? Yes / No
Name of Sleep Testing Facility Last Used: _____ Date: _____
Cardiologist Name: _____ or None
Pulmonologist Name: _____ or None
Neurologist Name: _____ or None
Other Physicians Currently Seeing: _____

Please check all that apply:

| | | | |
|---|---|---|---|
| □ AIDS/HIV | □ Emphysema / COPD | □ Osteoporosis | □ Thyroid Disease |
| □ Abnormal Bleeding | □ Excessive Daytime Sleepiness | □ Pacemaker | □ Thyroid Supplementation |
| □ Alcoholism | □ Fainting | □ Peripheral Vascular Disease | □ Tuberculosis |
| □ Anemia | □ GERD / Reflux | □ Peptic Ulcers | □ Other: _____ |
| □ Anxiety | □ Headaches | □ Pregnant _____ Weeks | □ Other: _____ |
| □ Artificial Heart Valve(s) | □ Heart Attack | □ Psychiatric Care | □ Other: _____ |
| □ Artificial Joint(s) | □ Heart Murmur | □ Radiation Therapy | □ Current Smoker: |
| □ Arthritis | □ Other Heart Condition | □ Sarcoidosis | Type: □ Cigarettes: ____Packs/Day |
| □ Asthma | □ Hepatitis: Type _____ | □ Seizures | □ Pipe |
| □ Back Problems | □ Herpes | □ Sexually Transmitted Disease | □ Cigar |
| □ Cancer, Type/Diagnosis: _____ | | □ Sinus Problems | □ Other: _____ |
| □ Chemical Dependency | □ High Blood Pressure | □ Skin Rash | For How Many Years? _____ |
| □ Chemotherapy | □ Insomnia | □ Sleep Apnea | □ Previous Smoker: |
| □ CHF (Heart Failure) | □ Kidney Disease | □ Snoring | Type: □ Cigarettes: ____Packs/Day |
| □ Chronic Pain | □ Liver Disease | □ Stomach Pain/Ulcers | □ Pipe |
| □ Depression | □ Low Blood Pressure | □ Stroke or TIA | □ Cigar |
| □ Diabetes Type 1/II | □ Mitral Valve Prolapse | □ Swelling of Feet or Ankles | □ Other: _____ |
| □Drug Addiction | □ Narcolepsy | □ Swollen Neck Glands | Year Quit: _____ |

**Review of Symptoms (Some answers are redundant; please recheck if indicated)**

Please indicate with an "x" if you have any problems with the following:

| GENERAL: | HEAD, EARS, NOSE, THROAT: | BONES & JOINTS: | NECK: | REPRODUCTIVE: |
|---|---|---|---|---|
| ___ Appetite Changes | ___ Dizziness | ___ Back pain | ___ Neck Pain | ___ Impotence |
| ___ Marked Weight Change | ___ Headaches | ___ Joint Stiffness | ___ Neck Stiffness | ___ Lack of Sex Drive |
| ___ Night Sweating | ___ Nosebleeds | ___ Muscle Cramps | | |
| ___ Recent Trauma/Infection | ___ Ringing in Ears | ___ Myalgia | LUNGS & HEART: | NEUROLOGIC: |
| ___ Sensitivity to Heat/Cold | ___ Sinus Infections | | ___ High Blood Pressure | ___ Cephalgia |
| ___ Tires Easily | ___ Sore Gums or Tongue | HEMATOLOGIC: | ___ Persistent Cough | ___ Dizziness |
| ___ Unusual Weakness | ___ Sore Throat or Hoarseness | ___ Anemia | ___ Shortness of Breath | ___ Headaches |
| ABDOMEN: | ___ Trauma | ___ Bleeding Disorder | ___ Wheezing | ___ Muscle Weakness |
| ___ Heartburn | | ___ Bruise Easily | ___ Swelling of Ankles | ___ Muscle Paralysis |

## MEDICATIONS, SURGICAL HISTORY AND ALLERGIES

**Drug/Medication Allergies:** □ None known □ Allergy to Latex □ Allergy to Methylmethacrylate

| Medication | Reaction | Medicine | Reaction |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**List any Prior Surgical History and Dates:**

| Date | Surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List any other Hospitalizations or Procedures in the past:**

| Date | Surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list any current medications including prescribed, over-the-counter (herbals, vitamins) you are presently taking:**

| Medication | Dosage | Reason for Taking |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**EPWORTH SLEEPINESS SCALE:** How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 mark the most appropriate box for each situation.

**0 = would never doze | 1 = slight chance of dozing | 2 = moderate chance of dozing | 3 = high chance of dozing**

| | | | | |
|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting, inactive, in a public place (theater, meeting, etc.) | 0 | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon when circumstances permit | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after lunch without alcohol | 0 | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic | 0 | 1 | 2 | 3 |

Total Score ☐

How many hours of sleep do you generally get each night? _____
How many times do you awaken during a typical night? _____
How many times do you urinate during the night? _____
Do you have trouble going to sleep? Yes / No
How long does it take you to fall asleep? _____
Before Bedtime, Do you:
Watch TV? Yes / No Use cell phone? Yes / No Tablet? Yes / No Computer? Yes / No
Do you:
Use any sleep aid? Yes / No Type: _____
Have frequent night time awakenings? Yes / No How many times? _____
Have difficulty returning to sleep during the night? Yes / No
Sleep walk or sleep eat during the night? Yes / No
Act out or have violent behavior during the night? Yes / No
Do pets or children sleep in bed with you? Yes / No
Have you been told that you:
Stop breathing or gasp during your sleep? Yes / No
Do you awaken with:
Morning headaches? Yes / No Sore throats? Yes / No Jaw Pain? Yes / No

Is there any other information that you feel Dr. Shults needs to know about your medical history?

_____

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I have reviewed the information provided on these forms and have completed it to the best of my knowledge. I understand this information will be used by the Doctor and Staff to aid with the dental/medical treatment provided for myself/dependent. The information provided will be held in strict confidence in accordance with HIPAA Regulations. If there is a change in my health, it is my responsibility to notify the doctor/staff accordingly. I authorize Powell Dental Group/Powell Dental Sleep Solutions to take digital x-rays, photographs, study models or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental sleep medicine needs. I authorize payment directly from my insurance company to Powell Dental Group for all insurance benefits otherwise payable to me for services rendered. I authorize Powell Dental Group to release any and all information necessary to my insurance company, if required, strictly for the purpose of acquiring reimbursement for dental services. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Patient Name** | **Name of Responsible Party** | **Signature of Responsible Party** | **Date** |

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# Affidavit for Intolerance To CPAP

(Indicated for use for medical insurance claims. This will not affect ability to obtain CPAP supplies)

## Please check all that apply:

- ☐ Mask Leaks
- ☐ Inability to get the Mask to Fit Properly
- ☐ Discomfort Caused by the Straps and Headgear
- ☐ Disturbed or Interrupted Sleep Caused by the Presence of the Device
- ☐ Noise from the Device Disturbing Sleep or Bed/Partner's Sleep
- ☐ CPAP Restricted Movements During Sleep
- ☐ CPAP Does Not Seem to Be Effective
- ☐ Pressure on The Upper Lip Causes Tooth Related Problems
- ☐ Facial Soreness from the Mask
- ☐ Latex Allergy
- ☐ Claustrophobic Associations
- ☐ An Unconscious Need to Remove the CPAP Apparatus at Night
- ☐ Get Tangled in Hose at Night
- ☐ Feel Worse When Using CPAP/PAP/APAP
- ☐ Prefer Oral Appliance Therapy
- ☐ Other: _____

Because of my intolerance/inability to use the CPAP/PAP/APAP, I wish to have an alternative method of treatment. That form of therapy is oral appliance therapy (OAT).

Signed: _____

Printed Name: _____

Witness: _____

Date: _____

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## Financial Policy

We welcome you to Powell Dental Sleep Solutions, the office of Dr. Shelley Shults. We look forward to providing you with the most exceptional dental/medical/sleep medicine care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent form. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible. We feel that communication between the office/patient is essential to provide excellent care to avoid the least amount of confusion.

- ***Payment for treatment is due at the time services are provided****. Accepted forms of payment include cash, check, Mastercard, Visa, Discover, and American Express. Financing options with credit approval is also available with CareCredit and Lending Club. If financing arrangements are required, this must be discussed with the billing office prior to the appointment whenever possible.*
- *Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $50 NSF check fee in addition to the account balance.*
- *Per the State of Ohio Law, if you have insurance, copayments and deductibles are due at the time of service. If a copayment needs to be billed, there will be a $15 processing fee.*
- *If a minor is unaccompanied for their appointment and a copayment is due, arrangements must be made with the office prior to the appointment.*
- *We accept any insurance that allows patients to see any provider of their choice. It is the patient's responsibility to verify if our offices are in network for their insurance carrier.*
- *If your insurance requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your visit.*
- ***Patients with Medicare****: Powell Dental Group/Powell Dental Sleep Solutions participates with and will bill directly to Medicare and your secondary insurance if secondary insurance information has been provided. If your secondary insurance does not respond in a timely manner, the patient will be responsible for any unpaid balance. It is the patient's responsibility to verify if Powell Dental Group/Powell Dental Sleep Solutions is in your network.*
- *As a complimentary service, our offices will file your claims for you. We do ask that the correct insurance information be provided so we can submit your claim accurately. If incorrect information is provided, you will be required to pay for your visit in full at the time of service. You can personally submit your claim to your insurance company for reimbursement.*
- *We emphasize that as dental and medical care providers, our relationship is with you, not the insurance company. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier directly to rectify the problem. All unpaid insurance balances older than 90 days from the date of service becomes the immediate responsibility of the patient/account holder. Please be aware that some services you may receive may not be covered by your insurance. Any estimate of insurance payment given by our office does not guarantee that your insurance company will reimburse us/you according to the estimate. Any unpaid balance not paid by the insurance company is the responsibility of the patient.*
- *Balances older than 90 days will be subject to a monthly billing charge of $5.00 if payment is not received on the account. Any balance older than 90 days will be subject to interest charges of 1.5% per month until the account is paid in full. Any past due account balance older than 90 days risks being sent to a collection agency. Any additional collection fees will be applied to the past due account balance and are the responsibility of the patient.*
- *In an effort to keep costs down while maintaining a high level of professional care, we respectfully request a 24-hour notice for cancellation of an appointment. If a 24-hour notice is not given for appointments, a $50 charge to your account may be applied. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and prescheduled availability for you.*
- *If you are 10 minutes late for your appointment, at the office manager's/Doctor's discretion, you may be asked to reschedule and may be charged a missed appointment fee.*

Our Purpose Statement is to provide services that exceed our patient's expectations with compassion, excellence and value, serving each other with care and respect, operating a practice that is strong, financially sound and state of the art, committed to never ending improvement. We pride ourselves in communication with our patients. If at any time, you have any questions, please do not hesitate to ask.

***By signing this form, I acknowledge that I have read and understand Powell Dental Sleep Solutions' office policies. I have had the opportunity to have any questions answered to the best of Sleep Solutions of Columbus' ability.***

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Patient Name** | **Name of Responsible Party** | **Signature of Responsible Party** | **Date** |

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## Notice of Privacy Practices for Protected Health Information

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.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Updated Notice takes effect April 24, 2014 and will remain in effect until we replace it.

We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes in accordance with Section 164.520 of the code of Federal Regulations. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time.

For more information about our privacy practices or for additional copies of this Notice you may contact:

**Powell Dental Group, LLC**
Dr. Shelley D. Shults, RN, DDS, D.ABDSM
39 Clairedan Drive, Powell, Ohio 43065
614.436.4433

If you believe your privacy rights have been violated, you may make a complaint to one of the above addresses.
The individual will not be retaliated against for making a complaint.

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**SECTION A: PERSON/PATIENT GIVING CONSENT**

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____ Relationship to Patient: _____

Address: _____ Telephone: _____

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. During the course of dental treatment, it may become necessary to disclose your protected health information to another entity, and agree to give consent to such disclosure for these permitted uses, including disclosures via email/fax.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description or our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent as permitted by Section 164.506 of the code of Federal Regulations.

**SECTION C: USE AND DISCLOSURE OF HEALTH INFORMATION** (You are not required to share/restrict information to anyone)

I, _____, wish to ( ☐ allow ☐ restrict ) disclosure of my health information to:

_____ (name), _____ (relationship).

I may revoke this disclosure with written notice to Powell Dental Sleep Solutions and affiliates at any time.

**SECTION D: RELEASE OF INFORMATION / SIGNATURE**

I request that payment of authorized health insurance benefits or Medicare benefits be made on my behalf to Powel Dental Sleep Solutions, dba Powell Dental Group for any services provided to me. I authorize any holder of medical/dental information about me to release to CMS and its agents or my designated insurance carrier, any information needed to determine benefits/benefits payable for related services. I authorize Powell Dental Sleep Solutions and related businesses/physicians/employees to release any necessary medical information about me to any third party or individual from whom payment for services may be rendered for purposes of obtaining a consultation, making a referral, continuity of my medical/dental care, quality assurance or peer review committee.

I have had the full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient/Legal Guardian Signature: _____ Date: _____

If acting on behalf of a minor or if you are the legal guardian/Medical Power of Attorney, please inform Sleep Solutions of Columbus of:

Patient's Name: _____ Your Relation to Patient: _____

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# ***Informed Consent for the Treatment of Obstructive Sleep Apnea***

Obstructive sleep apnea (OSA) is a medical condition that may be appropriate to treat with a custom device that opens the airway and is stabilized by your teeth or dental arch called oral appliance therapy (OAT). For OSA to be treated by a dentist, a diagnosis of OSA must be made by a physician trained in Sleep Medicine, using a sleep study polysomnogram or home sleep test. If you have not been diagnosed with OSA by your physician, please understand that Dr. Shelley Shults (RN, DDS, D.ABDSM) will not proceed with treatment without a diagnostic sleep study, that is no more than 3 years old, by the attending physician. Dr. Shults will work in collaboration with your physician to achieve the best results possible for the treatment of your sleep apnea.

**SUCCESFUL TREATMENT:** Oral appliance therapy is a very effective treatment for OSA. However, no therapy works 100% of the time. The mandibular advancement device (MAD or OAT) works by moving the jaw and tongue forward at night which acts to keep the airway open. As with any medical therapy, successful treatment of OSA using dental appliances cannot be guaranteed. Success depends on many things. The most important component of success is patient compliance. By signing this document, you hereby agree to follow Dr. Shults' instructions in detail. Failure to do so may result in a poor clinical outcome.

**COMPLICATIONS OF TREATMENT:** OSA is an unusual disease because it has been associated with many co-morbid medical conditions. As a result of OSA, or as a complication of OSA treatment, patients may develop any or all of the following: temporary or permanent co-morbid diseases, coronary artery disease, high blood pressure, diabetes, cerebrovascular disease, stroke, heart problems, heart attack, atrial fibrillation, depression, mood disorders, sexual dysfunction, weight gain, obesity, excessive daytime sleepiness, increased work related and traffic related accidents, and death.

**DENTAL ISSUES:** A number of temporary or permanent dental issues can develop as a result of long term treatment of OSA with OAT/MAD including but not limited to: jaw joint pain, moderate or severe TMJ dysfunction, headaches, backaches, neck aches, pain when chewing, facial pain, popping and noise in jaw, sore teeth, dental decay, gum (periodontal disease), gingivitis, worsening of periodontal pockets, tooth loss, loosening of teeth, dry mouth or excess saliva, fracturing or loosening of dental fillings/crowns/bridges, short term or long term bite changes, spacing or shifting of teeth, tilting of teeth, profile changes, lessening of overbite or overjet, dental infection, infection of the gums, difficulty chewing, oral cysts, oral tumors, oral cancer and death.

You should be aware that complications as a result of oral appliance therapy have been minor. However, it is the patient's responsibility to immediately inform Dr. Shults of any issues which may develop to prevent a permanent condition or complication.

Patient Initials _____

**FINAL SLEEP STUDY AND EVALUATION:** After your appliance is placed, it will be adjusted by Dr. Shults to achieve the best results possible. When your apnea symptoms have improved and Dr. Shults is satisfied with the results of the adjustments, you will be referred back to your physician for post-treatment evaluation and a post-treatment sleep study. This evaluation is to ensure that your apnea is adequately controlled by the OAT/MAD and that no further adjustments or other treatment is needed. Your treatment must be confirmed by a study and evaluation by your physician after Dr. Shults completed the adjustments.

**FOLLOW UP APPOINTMENTS:** Appointments are required with Dr. Shults on a minimum 6-month basis for the first year, followed by an annual basis to check the effectiveness of your appliance and the success of your OSA treatment. Failure to maintain these follow up appointments will constitute a lack of compliance with Dr. Shults' treatment plan. Any decision on your part to forego follow up appointments places your health at risk and increases the probability of complications and treatment failure.

Additionally, recall appointments should be kept with your general dentist on a 3-month schedule for the first year that you wear OAT/MAD, to evaluate your dental hygiene, gums and check for decay. By signing this agreement, you agree to schedule the recommended recall appointments and if determined by your dentist, to use prescription oral topical fluoride daily for the prevention of decay and periodontal disease. The prescription fluoride is to be used for as long as you wear an OAT.

**ALTERNATIVE TREATMENTS**: By signing this consent form you acknowledge that you have been made aware of reasonable alternatives to OAT therapy for OSA including, but not limited to: tracheostomy, CPAP, oral or pharyngeal surgery, positional sleep therapy, weight loss and exercise. Additionally, you are aware that more than one treatment may be necessary for the best results.

**WHEREFORE:** I give my consent for the treatment of my OSA using an oral appliance for mandibular advancement. I agree and consent to allow Dr. Shults and her staff to examine my mouth, teeth, jaws, gums and associated structures. I give consent for the taking of x-rays, photos, impressions and any other procedures necessary for the treatment of my OSA. I also give consent for a home sleep calibration study if necessary, for the adjustment of my appliance. I understand this involves a one time, non-refundable fee of $40 for the disposable kit and the calibration study is performed at no fee, evaluated by software algorithm and not a sleep physician. I consent for the contents of my records to be shared with my physicians and insurance company.

I affirm that I have read this document and have been given adequate information regarding treatment of my condition to give my informed consent. I understand the proposed treatment of my OSA and I have been given the opportunity to ask questions. All of my questions have been answered. My signature serves as consent to proceed with treatment when I desire.

Patient Signature: _____ Date: _____

Please Print Patient Name: _____

Witness: _____Date: _____

Printed Witness Name: _____