

SLEEP DISORDER CENTER SUPPLEMENTAL QUESTIONNAIRE

Your Full Name: _____

Policy Number: _____

(Please Print)

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 4.** **NOTE:** If there are sleep centers at multiple locations, please complete a questionnaire for each location.

Section I: Practice Information

1. Name of sleep disorder center: _____

2. Location: _____
Street City County State Zip

3. Do you maintain an ownership interest in the center? **Yes** **No**

If yes, please complete the following:

a. Please identify the legal structure of the center *and* provide a copy of the center's partnership agreement or articles of incorporation, as appropriate:

- Solo Medical Corporation Other Medical Corporation
 Partnership Other (please specify): _____

b. Does the center function under a different name from that which is filed under its partnership agreement or articles of incorporation, or, if it is not filed as a legal entity, does it operate under a different name from yours (i.e., a fictitious name or dba)? **Yes** **No**

If yes, please provide a copy of the fictitious name permit.

4. If you do not maintain an ownership interest in the center, please identify the type of relationship you maintain with it:

- Independent Contractor Employee Other (please specify): _____

5. If you maintain an ownership interest in the center, do any other persons or entities maintain an ownership interest in it?
 Yes **No**

If yes, please identify all such persons/entities and the percentage of their ownership interest:

NOTE: Please complete questions 6 and 7 only if you maintain an ownership interest in the center. Otherwise, please go to question 8.

6. Do any physicians other than you render services in or on behalf of the center? **Yes** **No**

If yes, please complete the following. Please photocopy this page if additional space is needed:

Name of Physician	Type of Relationship with the Center
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____

* Please provide copies of any contracts and proof of professional liability insurance for any non-employee not currently insured with NORCAL.

7. Do any ancillary healthcare personnel provide patient care in or on behalf of the center? **Yes** **No**

If yes, please complete the following. Please photocopy this page if additional space is needed:

Name and Designation	Type of Relationship with the Center
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____

* Please provide copies of any contracts and proof of professional liability insurance for any non-employee not currently insured with NORCAL.

8. Are you responsible for supervising any ancillary healthcare personnel who provide patient care in or on behalf of the center?
 Yes **No**

If yes, please complete the following. Please photocopy this page if additional space is needed:

Name and Designation	Type of Relationship with You
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____
	<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor* <input type="checkbox"/> Other*: _____

* Please provide copies of any contracts and proof of professional liability insurance for any non-employee not currently insured with NORCAL.

9. Do you or does the center advertise? **Yes** **No**

If yes, please provide copies of all advertisements.

10. Do you or does the center have a web site related to the practice of medicine? **Yes** **No**

If yes, please provide the web site address(es): _____

11. Is the center *currently* accredited by the American Academy of Sleep Medicine? **Yes** **No**

a. **If yes,** please provide proof of its accreditation.

b. **If no,** has the center ever been denied accreditation or has its accreditation ever been revoked? **Yes** **No**

If yes, please explain and provide a copy of the inspection results from the inspection that resulted in the denial or revocation:

12. Please identify the type of services that are provided at the center (please check only one):

- Services and treatment related **only** to sleep-related breathing disorders; *or*
- Services and treatment for any sleep disorder

13. Please provide the name(s) of the center's medical director(s)? _____

14. How many nights per week is the center open? _____

15. How many sleeping rooms does the center have? _____

16. How many sleep disorder studies have been performed in the center in the last year (for new centers please indicate the anticipated number to be performed in the next year)? _____

17. How close is the center to the nearest hospital emergency department (in miles)? _____

18. Do you or any other physicians perform surgical procedures in the center or any facility associated with the center?
 Yes **No**

If yes, please identify the procedures performed, types of anesthesia used, and who is performing each procedure:

19. Does the center maintain written policies for each of the following (please check all that apply)?

- Patient acceptance
- For each procedure performed
- Quality assurance
- Duties and responsibilities for each position

If you did not check any one of the above, please explain:

20. Does the center maintain written policies for the handling of emergency situations *and* are all healthcare personnel trained on them? **Yes** **No**

21. Does the center have a defibrillator and supplemental oxygen immediately available for emergency situations? **Yes** **No**

22. Is a complete medical record established for each patient seen at the center? **Yes** **No**

If you answered no to question 20, 21 or 22, please explain:

23. Does the center's informed consent process require written informed consent from each patient before he/she undergoes a sleep disorder study? **Yes** **No**

If no, please explain:

24. Please answer the following questions regarding the center's sleeping rooms.

a. Do patients ever share sleeping quarters? **Yes** **No**

If yes, please explain under what circumstances this occurs:

- b. Is the center equipped with equipment capable of recording continuous oxygen saturation and EKG of patients during testing?
 Yes No
- c. Is each sleeping room equipped with a two-way intercom, low light or infrared video monitoring, and recording instruments?
 Yes No

If you answered no to question 24b or 24c, please explain:

25. Please answer the following questions regarding the center's technicians and staff:

- a. What is the minimum number of sleep-related CME or CME-equivalent educational activities each member of the center's professional and technical staff is required to participate in per year (in hours)? _____
- b. What is the maximum number of patients assigned to one technician in a night? _____
- c. Are all technicians who are performing polysomnography registered polysomnographic technicians? Yes No
 If no, has a physician qualified in sleep medicine ensured that each technician is qualified to perform polysomnography?
 Yes No
- d. Do all technicians work under the direction of a licensed physician? Yes No
- e. Do the technicians follow written protocols? Yes No
- f. Does a physician qualified in sleep medicine verify the accuracy of all interpretations of polysomnograms? Yes No
- g. Is a person certified in cardiopulmonary resuscitation always on-site when patients are undergoing studies? Yes No

If you answered no to question 25d, 25e, 25f, or 25g please explain:

SECTION II: REMARKS

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

Print Name