NorthStar
MEDICAL SPECIALISTS

SLEEP DISORDERS CENTER

MEDICAL & SURGICAL WEIGHT MANAGEMENT

PULMONARY REHABILITATION

1345 King Street
Bellingham, WA 98229-6223
T: (360) 676-1696
F: (360) 676-6636
www.northstarmedicalspecialists.com

Informed Consent for Services

Consent For Treatment: I _____ (name) voluntarily consent to evaluation, treatment, diagnostic testing and therapy, which my physician and/or his/her designees determine to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result to examination or treatment in this facility. I have received the *Understanding Your Sleep Study* document and I understand the risks inherent to diagnostics and treatment.

Use of Medical Records in Research: I authorize the use of my medical records for medical or scientific research. I may disagree with the use of my medical records for this purpose by crossing through this paragraph and initialing in the left margin.

Consent for Personnel in Training: I am aware that patients at this facility may be attended by medical, nursing, and other health care personnel in training, who may be present during patient care as part of their education.

Consent for Photos: I consent to the taking of a video record for medical record documentation and diagnostic purposes.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that facility personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Insurance Consent: I request that payment of authorized benefits be made to NorthStar Medical Specialists and the facility's participating physicians for any services furnished to me. I authorize this facility to release to Medicare and/or accident or health insurer, medical or financial information as needed for claims processing, fraud investigation or quality of care review and studies. I understand that I may revoke this consent for release of information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company regarding pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay NorthStar Medical Specialists for all charges not covered by any third party payor.

Grievance procedure: I acknowledge that the Operations Director and Medical Director, make themselves readily available to discuss my concerns or questions I may have. I acknowledge that if I have a grievance of any kind, I have the right to utilize the Section 504 Grievance Procedure, posted in the facility lobby.

_____ _____ _____

Patient Signature (or legal representative) Relationship to patient Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

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Patient Registration

Patient's full name:_____ Social Security Number:_____

Mailing Address:_____Apt#:____ Birthdate:___/__/____

City/State/Zip:_____

Home Phone#:_____ Work Phone#:_____ Sex:_____ Age:_____

Employment Status (circle one): Full time / Part time / Not employed / Self employed / Retired / Student

Marital Status: Single / Married / Divorced / Separated / Widowed Spouse's Name:_____

In case of emergency, contact:_____Phone#:_____

Relationship to patient: _____ Spouse's Employer: _____

Referring physician:_____Primary care physician:_____

Reason for referral: _____

How did you hear about NorthStar Medical? (circle one below)

Doctor referral / Friend/family referral / Newspaper / Radio / Other _____

Name of Primary Insurance Company:_____

Subscriber's name:_____ Date of Birth:_____

Subscriber's relationship to patient:_____

Subscriber's #:_____ Group #:_____

Name of Secondary Insurance Company:_____

Subscriber's name:_____Date of Birth:_____

Subscriber's relationship to patient:_____

Subscriber's #:_____ Group #:_____

Sleep Habits

Weekday bedtime: ___am/pm Weekday awaken time: ___am/pm Do you use an alarm? Yes No

Weekend bedtime: ___am/pm Weekend awaken time: ___am/pm Do you use an alarm? Yes No

Do you notice any seasonal changes in sleep and mood between summer and winter? Yes No

Please describe: _____

How many times do you awaken on a typical night? _____

Do you have difficulty falling back to sleep after awakening? Yes No

Causes for awakenings: (circle all that apply)

Snoring	Nightmares	Full bladder	Bedroom noise
Worry	Pain	Thirst/hunger	Bed partner
Headache	Heartburn	Choking/gasping	Night sweats

Other: _____

Do you nap intentionally? Yes No

If so, how many times per week? _____ What time of day? _____ How long are naps? _____

Describe your usual bedtime routine for the hour or two hours before bedtime: _____

_____

_____

Social History

Marital status: (circle one) Single / Married / Widowed / Divorced / Partner

Number of children: ____ Number living at home: _____ Ages: _____

Work status: (circle one) Full-time / Part-time / Retired / Unemployed / Self-employed / Disabled / Student

Shift worker? Yes No What shift? _____

Occupation: _____

Do you and your partner sleep in the same room? Yes No

Do you sing or play a wind instrument? Yes No

Caffeine-containing beverages consumed on a typical day:

Coffee _____ Tea _____ Soda _____

Time you would typically consume your last caffeinated drink? _____am/pm

Alcohol consumption typical for you:

Drinks per week: _____ Drinks per day: _____ Tobacco Use: Yes No

If yes: Number of years smoking: _____ Average packs per day _____

If no: Former smoker? Yes No Approximate years smoked: _____ Average packs/day: _____

Recreational drug use? (Marijuana, cocaine, etc.) _____

Past Medical History

In general, would you say your health is: (circle one) Excellent / Very Good / Good / Fair / Poor

Current weight ____ Height ____ Collar size (men) _____

Weight one year ago ____ At age 18 ____

How often do you experience each of the following? (circle your response)	**Almost never**	**Rarely (once a month)**	**Some (once a week)**	**Often (2-4 times a week)**	**Almost Every Night**
I have trouble falling asleep.	0	1	2	3	4
I wake up during the night and have difficulty getting back to sleep.	0	1	2	3	4
I have frequent awakenings at night but *no* difficulty returning to sleep.	0	1	2	3	4
I wake up too early in the morning and am unable to get back to sleep.	0	1	2	3	4
I have difficulty waking in the morning.	0	1	2	3	4
I do not get enough sleep.	0	1	2	3	4
I am sleepy during the day.	0	1	2	3	4
Daytime fatigue is a problem for me.	0	1	2	3	4
Snoring.	0	1	2	3	4
Wake up choking or gasping from sleep.	0	1	2	3	4
Wake up with dry mouth.	0	1	2	3	4
Wake up with sore throat.	0	1	2	3	4
Morning headaches.	0	1	2	3	4
Nasal/sinus congestion.	0	1	2	3	4
Wake to urinate 2 or more times per night.	0	1	2	3	4
Wake up with shortness of breath.	0	1	2	3	4
Heartburn interfering with sleep.	0	1	2	3	4
Grind teeth while sleeping.	0	1	2	3	4

Nightmares	0	1	2	3	4
Sleep walking.	0	1	2	3	4
Sleep talking.	0	1	2	3	4
Acting out dreams.	0	1	2	3	4
Kicking/jerking of legs while sleeping.	0	1	2	3	4
Restlessness or discomfort in legs.	0	1	2	3	4
Hallucinations when falling asleep or upon awakening.	0	1	2	3	4
Momentary complete paralysis when falling asleep or upon awakening.	0	1	2	3	4
While awake, you have episodes of muscle weakness brought on by strong emotion.	0	1	2	3	4

How likely are you to doze off or fall asleep (not just feel tired) in the following situations? 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 circle the most appropriate response for each situation.

	No Chance	**Slight chance**	**Moderate chance**	**High chance**
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting inactive in a public place (like a theater or a meeting).	0	1	2	3
Riding 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
At the dinner table.	0	1	2	3
While driving.	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

How would you rank the intensity of your snoring on a scale of 0-5, with 0 being “no snoring” and 5 being ”earth shattering” ? _____

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HEALTH STATUS QUESTIONNAIRE

Patient Name:_____ Date:_____ Primary Physician:_____

Head/Eyes/Nose/Throat	No	Yes	Physician/ Therapist
Hearing Loss?			
Vision loss?			
Glaucoma?			
Cataracts?			
Sinus Problems?			
Seasonal Allergies?			
TMJ Disease/Problems?			
Snoring Problems?			
Neurological			
Headaches?__Migraines? __			
Seizures? __Last one? __			
Stroke? __When? __			
Numbness anywhere?			
Muscle disease? _____			
Respiratory			
Shortness of breath?			
Recent cold or sore throat?			
Chronic cough?			
Asthma? __episodes/wk__			
Emphysema?			
Use inhalers 0 times/wk__			
Home oxygen?			
Sleep Apnea?			
Cardiovascular			
High blood pressure?			
Heart Attack?			
Chest pain (angina)?			
Pacemaker/defibrillator?			
Irregular heart rhythm?			
Murmur?			
Prosthetic Heart Valve?			
Phlebitis/blood clots?			
Congestive heart failure?			
Circulation Problems?			
Heart catheterization?			
Gastrointestinal			
Swallowing problems?			
Hiatal hernia/heartburn?			
Peptic ulcer disease?			
Hepatitis? __A__B__C			
Other liver disease?			
Nausea & vomiting?			
General Health			
Recent fever			
Recent chills			
Unexplained weight loss			
Loss of appetite			

Endocrine	No	Yes	Physician/ Therapist
Diabetes? How long? __			
Insulin__ Oral agent__			
Thyroid disease?			
Hematologic			
Bleeding problems?			
Anemia?			
Immune Disorders?			
Recent blood transfusion?			
Willing to receive blood transfusion?			
If medically necessary			
Under No Circumstances			
Waiver signed			
Surgeon notified			
Skin/Lymphatics			
Enlarged glands?			
Rashes?			
Cancer			
What type?			
When?			
Treatment?			
Musculoskeletal			
Back or neck problems?			
Arthritis?			
Physical limitations?			
Genitourinary			
Kidney failure?			
Infections?			
Prostate problems?			
Last menstrual period__			
Could you be pregnant?			
# pregnancies__#live births__			
Birth control method?			
Pills_____Other_____			
Other Information			
Do you have a living will?			
Do you have a power of attorney?			
Do you live alone?			
Prosthesis/Implants/Devices			
Heart valve_____			
Joint_____			
Eyes_____			
Artificial limb_____			
Hearing aides_____			
Dentures/partials_____			
Contact lenses___ Glasses___			
Walker/wheelchair/cane?			

Height:_____ Weight:_____

Previous Surgeries	**Current Medications**
	Prescription? Include Dosage
Problem with anesthesia or a family member with an	
anesthetic problem?	
Allergies	
Medications?	Non-Prescription Drugs
Food?	
Latex	**Habits**
Iodine?	
Tape?	
Soy Products?	
Other?	

Patient Signature:_____Date:_____

Physician/Therapist: Signature:_____Review Date:_____Updates:

Comments:

_____
_____
_____
_____
_____

Special Needs

Please notify our office immediately if you have specific assistance requirements. This includes, but is not limited; sight, hearing, mental health and physical disabilities.

Northstar Medical Specialists has specific policies in place to accommodate your needs while protecting the health and well being of other patients. If you require a service animal, please notify our office immediately.

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The questions listed below are for Beneficiaries age 65 or older, and is used to comply with Medicare Regulation 42 CFR 489.20 (F). If this does not apply to you, please skip to next page.

Primary Payor Questionnaire

Name of Patient: _____ SSN: _____

1. Are you currently working full or part-time? **Yes / No**
2. If married, is your spouse working full or part-time? **Yes / No**
3. Are you currently under any employer group health plan? **Yes / No**

   If yes; Name of insured:_____

   Relationship to patient:_____ Name of employer:_____

   Name of carrier:_____ Group/policy#:_____
4. Are you entitled to Black Lung Benefits? **Yes / No**
5. Is this service for treatment work related? **Yes / No**

   If yes; Name of insurer:_____ Date of injury:_____

   Name of employer:_____ Policy/claim#:_____
6. Is this service for treatment related to an auto injury? **Yes / No**

   If yes; Name of insurer:_____ Date of injury:_____

   Name of policyholder:_____ Policy/claim#:_____
7. Are benefits for services being submitted to any other party for reimbursement consideration? **Yes / No**

Patient Signature:_____ Date:_____

Witness:_____

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Notice of Privacy Practices

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.

The privacy of your medical information is important to us. At NorthStar Medical Specialists, we respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others for non-permitted uses and disclosure unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to get authorization to disclose this information for payment purposes.

Use and disclosure of protected health information for treatment, payment, and health operations, to remind you, notification of family, for public health and safety, and other uses as noted below.

For Treatment**:** Information obtained by a therapist, physician, technologist, or other member of our health care team will be recorded in your medical record and used to help decided what care may be right for you.

We may also provide information to others providing your care to help them stay informed about your care.

For Payment**:** We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations**:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about your appointments and give you information about treatment alternatives or other health related benefits and services
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
  - Medical review by your health plan;
  - Accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

To remind you:
We may remind you by phone, voicemail, or mail, that you have a health care appointment with us, or request that you call us regarding your health care. You have the right to request we contact you at an alternative addressor phone number. If you request this, we will contact you at the alternative location, as requested.

Notification of family and others:
We may disclose your private health information to a “personal representative” (a person who is legally authorized to make health care decision on your behalf, such as a parent of a minor child).
In addition, we may disclose health care information about you to assist in disaster relief efforts.
You have a right to object to this use or disclosure. If you object, we will not disclose it.

For public health and safety purposes as required by law:

- to prevent or reduce a serious, immediate threat to the health of a person or the public
- to public health and legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or death

To report suspected abuse or neglect
To the Food and Drug Administration relating to problems with products
In the course of judicial/administrative proceedings
For law enforcement purposes
To correction institutions if you are in jail
With approved medical researchers

To comply with workers compensation laws
For health and safety oversight activities, e.g., shared health information with the Department of Health

For disaster relief purposes
For work related conditions that could affect employee health
To the military authorities, U.S. and foreign
To funeral directors/coroners consistent with applicable laws
For specialized government functions such as national security purposes

Other uses and Disclosure of protected health information

Uses and disclosures not in this notice as allowed and required by law, or with your written authorization

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice;
- Abide by the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting us at NorthStar Medical Specialists to pick one up.

Your Health Information Rights

The health and billing records we create and store are the property of NorthStar Medical Specialists. The protected health information in your file, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but if we decide to, we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected Health information, you may make this request in writing.
- Have us review a denial of access to your health information - except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The privacy rule does not require accounting of disclosure to covered entities for treatment, payment, or health care operations, to the individual (or representative), to persons involved in the individual's health care, or payment for health care, pursuant to an authorization, of a limited data set, for nation security purposes, to law enforcement officials in certain circumstances, incident to otherwise permitted or required uses or disclosures;
- Ask that your health information be given to you by another means, or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance;

For help with these rights during normal business hours, please contact our Privacy Manager at NorthStar Medical Specialists.

To ask for help or complain

If you have questions, want information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Manager at NorthStar Medical Specialists.

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Manager. You may also deliver a written complaint to the Privacy Manager at NorthStar Medical Specialists. You may also file a complaint with the US Secretary of Health and Human Services.

We respect your right to file a complaint with us, or the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

While you participate in your treatment at NorthStar Medical, some of your activities and treatments will be conducted in a group setting. As a result, some of your protected health information may be discussed with you in the group setting. Please sign below if you agree.

_____ _____

Patient Signature Date and Time

_____

Printed Name

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CONSENT FOR THE RELEASE OF INFORMATION
(Specified Access)

Please complete this form to allow NorthStar Medical Specialists to release your personal information and/or medical records to an individual or group. For example; your referring physician, primary care provider, or any medical specialists. If you wish to share your protected health information at NorthStar with another party, you are required to complete this form.

I hereby authorize NorthStar Medical to release my medical records for treatments and services to _____.

This access includes: (Check all that apply)

____Reading and/or copying my written medical record

____Accessing, reading and printing my computerized medical record

____Receiving phone information regarding my medical condition and treatments

____Other: Please explain:_____

_____

This health care consent authorizes this access for the following time frames: (Check one)

____Between _____ and _____ (If patient is a minor this agreement ends when
Beginning date Ending Date patient becomes an adult)

____This agreement is open ended and I will notify NorthStar Medical specialists if I want it revoked.

I hereby release NorthStar Medical Specialists, its agents and employees from all legal responsibility or liability that may arise from the release of this information or records.

_____
Witness

_____
Patient Signature

_____
Social Security No.

_____
Date of Birth

_____
Custodial parent if patient is a minor

_____
Relationship

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Cancellation Policy

Thank you for choosing NorthStar Medical Specialists to help you achieve a better quality of life. In the interest of conserving your time, we will make every effort to stay on schedule. Your time is valuable and except for emergency treatment of another patient, you can expect us to be prompt.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment during business hours is appreciated.

When you schedule an appointment, that time has been set aside just for you. There will be a charge for appointments cancelled with less than sufficient notice. No-show and late cancellation fees must be paid before future appointments can be scheduled.

We will hold your appointment for 15 minutes after your scheduled start time. If you arrive late on the date of your appointment, you may be asked to reschedule; however, we will do our best to provide an excellent session with the remaining time. High standards of patient care depend upon equal treatment and consideration; therefore sessions must begin and end on time.

The cancellation/no-show fee schedule is as follows:

48-Hour Notice Required for all Appointment Cancellations:

Physician and physician assistant appointments	$75
Clinician appointments	$45
Respiratory therapy session	$45
Overnight sleep study appointments	$250

Please note, calls to cancel appointments should not be left on the office voice mail within the minimum time frame in attempt to avoid the cancellation fee. Doing so may result in a lapse of the 48-hour notice. If you have any questions or concerns, please do not hesitate to contact our office at (360) 676-1696. Thank you!

I have read and fully understand NorthStar Medical Specialists' Cancellation Policy.

_____ _____

Signature Date

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***(A)*Notifier(s):** NorthStar Associates, PLLC
***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance doesn't pay for the *Sleep Disorders Center* services below, you may have to pay.

Insurance providers may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that your insurance may not pay for the *Sleep Disorders Center* services below.

(D) Sleep Disorders Center Services	***(E)* Reason Insurance May Not Pay:**	***(F)* Estimated Cost:**
• Office Consultations with Dr. Webb • Office Consultations Meralee Byker, PA-C • Overnight Sleep Studies • Durable Medical Equipment and supplies	• It may not be deemed medically necessary • It may be an exclusion on your plan • It may be deemed investigational per your insurance company guidelines.	$4.88-$950 per service/item *(Depending on services rendered)*

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the *Sleep Disorders Center* services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but you insurance cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**
❑ **OPTION 1.** I want the *Sleep Disorders Center* services listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles. ❑ **OPTION 2.** I want the *Sleep Disorder Center* services listed above, but do not bill my insurance. I may ask to be paid now as I am responsible for payment. **I cannot appeal if insurance is not billed**. ❑ **OPTION 3.** I don't want the *Sleep Disorders Center* services listed above. I understand with this choice **I am** not **responsible for payment, and** I cannot appeal to see if my insurance would pay.

(H) Additional Information:

This notice gives our opinion, not an official decision. If you have other questions on this notice or medical insurance billing, call the customer service phone number on the back of your insurance patient identification card.

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

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Understanding Your Sleep Study

Introduction: Your physician has determined, or will determine by polysomnography (all night study of your sleep patterns), that your throat may become obstructed during sleep (obstructive sleep apnea). Some people obstruct more than others and require treatment. There are several modalities of treatment. If you show signs of sleep apnea, a trial of CPAP therapy will be initiated.
Procedure: To produce the CPAP effect, a small, soft cushioned mask will be placed over your nose and will rest on your face. It will not cover your mouth or eyes. A flow of air is supplied into the mask and a resistance valve is attached to the line, creating a small positive pressure in your nose and throat. You are free to breath through your mouth or nose. Breathing through your nose produces the optimal flow.

Monitoring: In order to monitor the effectiveness of the Nasal CPAP mask, a polysomnography test will be performed. The technician will attach monitoring electrodes to your scalp using either a paste or glue-like substance that is easily removed after the test. Tape is used to attach other electrodes to the skin around your eyes, on your chin, and on your legs. The various electrodes will monitor brain waves and muscle movements you make during the night.

Additional electrodes will be attached to your chest to monitor your heart rate. An elastic band will be wrapped around your waist in order to monitor abdominal movements during breathing. A small cannula, which monitors air movements, will be placed under your nose and in the front of your mouth. A finger clip is used to measure oxygen saturation of your blood.

After all these devices are attached, the wires will be connected to a box at the head of the bed and you will be allowed to go to bed and sleep.

Should your physician wish to determine the utility of supplemental oxygen during sleep, an oxygen line will be attached to your mask to provide oxygen to you. This procedure will help your physician determine whether supplemental oxygen would be of help to your breathing problems during sleep.

Once the study has begun, if you awaken and need to use the bathroom or get out of bed for any reason, you **must** call the technician. The wires to the jack box will restrict you from getting up without assistance. There is an intercom in the sleep room that is connected directly to the technologist room. To alert the technologist, simply speak and they will respond. Should you not get a response right away, continue to call. Please DO NOT attempt to detach yourself and get up without assistance. An attempt to do so could result in injury to you or damage the equipment. You may discontinue the CPAP or sleep study at any time just by asking the technologist to do so.

Benefits: If the CPAP is successful, you may be relieved of most of the upper airway obstruction and possible hazardous effects of such an obstruction. If used according to your physician's orders, the CPAP system may delay or prevent the need for surgical intervention.
Risk: Certainly, risks do exist although none have been reported in previous studies. If you increase the pressure in the airway, it is possible to transfer some of this pressure to the cardiovascular system (heart and blood vessels) thus, decreasing the pumping ability of the heart. It is also possible to have this pressure applied to the lungs. In rare circumstances, a person may have a weakened spot in the lung tissue and the air will leak out (pneumothorax). However, these risks will usually occur only with higher levels of CPAP than those in your study.

Although rare, there can be cardiac risks associated with CPAP treatment. However, CPAP treatment usually has either no impact or improves cardiac function.