

Consent, Release, and Notification for treatment, payment, and other health care operations.

Instructions: Please read form in its entirety, initial where necessary, and sign at the bottom.

Consent and Release

I, _____, hereby authorize Pulmonary Practice Associates, its practitioners, and its staff to use and/or disclose my health information, which specifically identifies me or can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Pulmonary Practice Associates can refuse to treat me.

I have received and/or reviewed a copy of the Notice of Privacy Practices (the "Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand I may revoke the consent at any time by notifying Pulmonary Practice Associates in writing. However if I revoke my consent, such revocation will not affect any actions that Pulmonary Practice Associates took before receiving my revocation.

I understand Pulmonary Practice Associates reserves its right to change its privacy practices and that I can obtain such change notification upon request.

I understand I have the right to request that Pulmonary Practice Associates restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health care operations. I further understand Pulmonary Practice Associates does not have to agree to such restrictions, but once such restrictions are agreed to, Pulmonary Practice Associates must adhere to such restrictions.

Initial

Appointment Reminder

Pulmonary Practice Associates...

...may leave a message at my home using doctor's/practice name: [] Yes [] No

...may leave a message at my work using doctor's/practice name: [] Yes [] No

Pulmonary Practice Associates has permission to discuss my medical care with myself and the following person(s):

Initial

Patient Responsibility and Notification Responsibility

I understand it is my responsibility to contact the office within 7-10 days after the study/test/procedure has been completed to verify results are negative/normal/stable and no other testing/office visit is necessary if my follow-up appointment is cancelled or rescheduled by myself or by Pulmonary Practice Associates after completing a radiological imaging study (X-ray, CAT Scan, MRI), or any other test/procedure.

Initial

I understand that my scheduled appointment time does not necessarily guarantee I will be seen by a clinician at that time, but instead it places me in an order to be seen. Also, I understand that if I am more than 10 minutes late for my scheduled appointment, I may be asked to reschedule my appointment. I further understand if I do not show for my scheduled appointment, I may be charged a minimum fee of \$25 per occurrence.

Initial

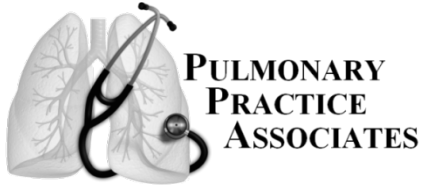
Attestation: By my signature below, I agree to all information stated herein and understand my rights and responsibilities as a patient of Pulmonary Practice Associates.

Signature of Patient or Patient Representative

Date

Printed Name of Patient or Patient Representative

Relationship to patient



Release, Authorizations, and Assignments

Instructions: Please read form in its entirety, initial where necessary, and sign at the bottom.

Release of Information

I authorize Pulmonary Practice Associates, MD, PA, to release to any insurance company or government agency any medical information contained in my records, when such material is required in connection with determining a claim for payment.

I authorize Pulmonary Practice Associates, MD, PA, to release any medical information accumulated in the course of my examination or treatment to any other doctor, hospital, or nursing home.

I authorize the release of any medical information contained in any other doctors' or hospitals' records to Pulmonary Practice Associates, MD, PA.

Initial

Insurance Assignment

I authorize payment from any insurance company or any governmental agency to Pulmonary Practice Associates, MD, PA, for any medical or surgical benefits otherwise payable to me for the services provided by Pulmonary Practice Associates, MD, PA, but not to exceed the reasonable and customary charge for these services.

Initial

Authorization of Care and Acknowledgment of Responsibility for Payment

I authorize Pulmonary Practice Associates, MD, PA, to examine me and order/perform such tests and/or procedures as are reasonable and necessary in the diagnosis and treatment of my case.

I understand that it is my responsibility to understand what professional services are covered/not covered by my insurance.

I understand that it is my responsibility to contact my insurance company to determine what is my out-of-pocket expense responsibility for services provided or will be provided to me for medical care.

I agree to pay Pulmonary Practice Associates, MD, PA, the professional fees in return for the above rendered services.

I agree that, should the amount of any insurance benefits be insufficient to cover the professional fees of services rendered to me for medical care, I will be responsible for the payment of the difference.

I agree to pay the entire amount of my professional fees if my professional fees are not covered by my insurance benefits.

Initial

Original Assignments, Authorizations, and Releases on File

I permit a copy of the above assignments, authorizations, and releases to be used in place of the original, which has been filed in the office of Pulmonary Practice Associates, MD, PA.

Signature of Patient or Patient Representative

Date

Printed Name of Patient or Patient Representative

Relationship to patient

PULMONARY PRACTICE ASSOCIATES: Registration Form

Directions: All sections must be completed. Write "N/A" if not applicable

1. PATIENT INFORMATION			
Patient's Last Name	First	MI	Date of Birth
		Age	
Former Last Name (if any)		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refuse To Respond		Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Refuse To Respond	
Mailing Address		City	State
		ZIP Code	
Home Address (if different from Mailing Address)		City	State
		ZIP Code	
Home Phone #	Cell Phone #	Email	
Chose Clinic Because/Referred to Clinic by		Other Family Members Seen Here	

2. INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) AND A PHOTO ID TO THE RECEPTIONIST)	
Is This Patient Covered By Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Not Covered by Insurance, Payment Is Due On The Date Of Service)	
Name of Primary Insurance _____ <input type="checkbox"/> PPO <input type="checkbox"/> HMO	
Patient's Relationship to Subscriber of Primary Insurance <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
If Not Primary Subscriber, Subscriber's Full Name: _____ Social Sec#: _____ DOB: _____	
Name of Secondary Insurance (if applicable) _____	
Patient's Relationship to Subscriber of Secondary Insurance <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
If Not Primary Subscriber, Subscriber's Full Name: _____ Social Sec#: _____ DOB: _____	

3. MEDICAL INFORMATION	
Pharmacy Name	Phone #
Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you allergic to Penicillin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list all medicine allergies: 1. _____ 2. _____ 3. _____	
List ALL medications you take including dosage (include any over the counter medications/vitamins):	
1. _____ 2. _____ 3. _____ 4. _____	
5. _____ 6. _____ 7. _____ 8. _____	

4. EMERGENCY CONTACT			
Name of Local Friend or Relative	Relationship to Patient	Home Phone #	Alternate Phone #

5. ADVANCED CARE PLANNING – Patients age 65 years and older only	
<input type="checkbox"/> I have an advanced care plan / living will and my Surrogate Decision Maker's Name is stated below. <input type="checkbox"/> I have an advanced care plan / living will but I do not wish or I am unable to name my Surrogate Decision Maker. <input type="checkbox"/> I do not have an advanced care plan / living will, but I would like information.	
My Surrogate Decision Maker's Name	Phone #

MEDICARE PATIENTS ONLY: I request payment of my MEDIGAP benefits be made to Pulmonary Practice Associates ("PPA") for services provided to me. I authorize PPA to release to my MEDIGAP company any information needed to determine benefits.	
Signature of Patient or Patient Representative	Date
Printed Name of Patient or Patient Representative	Relationship to patient

PULMONARY PRACTICE ASSOCIATES: Intake Form (Page 1)

Directions: All sections must be completed. Write "N/A" if not applicable

PATIENT INFORMATION

Name _____	DOB _____
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FAMILY HISTORY

Unobtainable/Unknown (Adopted)
 No Significant History
 Early Deaths

(Use the following: "M" = Mother, "F" = Father, "S" = Sister(s); "B" = Brother(s): *Who in your family has had...*)

Allergies _____	CAD _____	Gout _____	Renal (Kidney) Disease _____
Anxiety Disorder _____	Cancer _____	Heart Attack _____	Sarcoidosis _____
Arthritis _____	Cancer Type _____	Heart Disease _____	Seizure Disorder _____
<i>Arthritis Type</i> _____	Colon Cancer _____	High Cholesterol _____	Sleep Disorder _____
Asbestosis _____	COPD _____	High Blood Pressure _____	Stroke Syndrome _____
Asthma _____	Depression _____	Lung Cancer _____	Thyroid Disorders _____
Breast Cancer _____	Diabetes _____	Mental Disorder _____	Tuberculosis _____
Bronchitis _____	Emphysema _____	Prostate Cancer _____	Ulcers _____

Father's Side	Age	State of Health (If Living)	Cause of Death (If Applicable)	Age at Death
My Grandfather	_____	_____	_____	_____
My Grandmother	_____	_____	_____	_____
Mother's Side				
My Grandfather	_____	_____	_____	_____
My Grandmother	_____	_____	_____	_____
My Father	_____	_____	_____	_____
My Mother	_____	_____	_____	_____
My Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
My Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
My Child(ren)	M/F _____	_____	_____	_____
	M/F _____	_____	_____	_____
	M/F _____	_____	_____	_____

PULMONARY PRACTICE ASSOCIATES: Intake Form (Page 2)

Directions: All sections must be completed. Write "N/A" if not applicable

PATIENT INFORMATION

Name	DOB	Today's Date
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SOCIAL HISTORY

List **ALL OCCUPATIONS** including MILITARY HISTORY, from current occupation to previous.

Marital Status (Check One) Single Married Divorced Widowed Separated Engaged

Employment Status (Check One) Full Time Part Time Unemployed Retired Student

Occupation (If retired, write "Retired")	Employer	Employer Phone #
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Smoking History / Exposure: Do you smoke Cigarettes? Cigars? Pipe?

If you do not currently smoke, have you ever smoked? Yes No, If yes, when did you quit? _____

How much per day? _____ For how long? _____

Check all that apply: Wish to stop smoking. Recently stopped smoking. Unsuccessful attempt(s) to stop smoking.

Exposure to second-hand smoke? Yes No.

Do you use the following (check all that apply): Alcohol, ____ drinks per week. Caffeine, ____ cups per day.
 Drug Use, Type: _____

Do you have the following (check all that apply): Poor exercise habits Physical Disability Stress Exposure to TB
 Difficulty understanding the Native Language School/Work Absenteeism

Pet Exposure: Exposure to animals triggers a reaction? Yes No.

I have... had recent contact with pets or other animals. animals living in my home.
 Birds: How many? _____. Cats: How many? _____. Dogs: How many? _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having any of the following illnesses (check all that apply):

<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> CHF	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Mumps	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Alpha 1 Antitrypsin Deficiency	<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Arthritis: Type _____	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Polio	<input type="checkbox"/> Syncope
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> PVD	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disorder/Failure	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Kidney Disease End Stage	<input type="checkbox"/> Upper Resp. Infection
<input type="checkbox"/> CAD	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Mass/Nodule	<input type="checkbox"/> Restless Legs	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Cancer: Type _____	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Measles	<input type="checkbox"/> Restrictive Lung Disease	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> COPD	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other: _____

Previous Hospitalizations: Reason & Date _____

Your major problem at this time: _____

PULMONARY PRACTICE ASSOCIATES: Intake Form (Page 3)

Directions: All sections must be completed. Write "N/A" if not applicable

PATIENT INFORMATION

Name _____	DOB _____	Today's Date _____
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SURGICAL HISTORY

Please check any surgeries you have had and provide details (check all that apply):

Date and Details	Date and Details
General Surgery	
<input type="checkbox"/> Amputation(s) _____	<input type="checkbox"/> Kidney _____
<input type="checkbox"/> Aneurysm _____	<input type="checkbox"/> Knee _____
<input type="checkbox"/> Arm _____	<input type="checkbox"/> Neck _____
<input type="checkbox"/> Back _____	<input type="checkbox"/> Shoulder _____
<input type="checkbox"/> Breast _____	<input type="checkbox"/> Sinus _____
<input type="checkbox"/> Cataract _____	<input type="checkbox"/> Thyroid _____
<input type="checkbox"/> Facial _____	<input type="checkbox"/> Tonsillectomy _____
<input type="checkbox"/> Foot _____	<input type="checkbox"/> Uvuloplasty _____
<input type="checkbox"/> Hand _____	<input type="checkbox"/> Wrist _____
<input type="checkbox"/> Hip _____	<input type="checkbox"/> Other _____
Gynecological Surgery:	
<input type="checkbox"/> C-Section _____	<input type="checkbox"/> Mastectomy _____
<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> Oophorectomy _____
Cardiovascular Surgery:	
<input type="checkbox"/> AAA _____	<input type="checkbox"/> Heart Valve Replacement _____
<input type="checkbox"/> CABG _____	<input type="checkbox"/> Angioplasty _____
<input type="checkbox"/> Carotid Endarterectomy _____	<input type="checkbox"/> Pacemaker _____
<input type="checkbox"/> Stent _____	<input type="checkbox"/> Total # Performed _____
Gastro:	
<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> Hemorrhoidectomy _____
<input type="checkbox"/> Cholecystectomy _____	<input type="checkbox"/> Prostatectomy _____
<input type="checkbox"/> Colonoscopy _____	<input type="checkbox"/> Splenectomy _____
<input type="checkbox"/> Gastrointestinal _____	<input type="checkbox"/> Vasectomy _____
Hernia:	
<input type="checkbox"/> Hernia Repair _____	<input type="checkbox"/> Umbilical Repair _____
<input type="checkbox"/> Inguinal Repair _____	<input type="checkbox"/> Ventral Repair _____
Lung Surgery:	
<input type="checkbox"/> Bronchoscopy _____	<input type="checkbox"/> Lobectomy _____
<input type="checkbox"/> Lung Biopsy _____	<input type="checkbox"/> Lung Surgery _____
<input type="checkbox"/> Thoracentesis _____	<input type="checkbox"/> Pneumonectomy _____
<input type="checkbox"/> Excision of Lesion of Mediastinum _____	
<input type="checkbox"/> Excision Lesion of Chest Wall _____	
<input type="checkbox"/> Wedge Resection of Lung _____	

PULMONARY PRACTICE ASSOCIATES: ROS

Directions: All sections must be completed. Write "N/A" if not applicable

PATIENT INFORMATION		
Name _____	DOB _____	Today's Date _____

Height _____ Usual Weight _____ Present Weight _____

SYMPTOMS: Are you having any of these symptoms (check all that apply):	
<input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Chills <input type="checkbox"/> Rashes <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Sputum: <i>Color</i> _____ <input type="checkbox"/> Blood in Sputum <input type="checkbox"/> Headache <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> <i>Discharge drips down throat, causing cough</i> <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Swollen Glands (neck) <input type="checkbox"/> Sore Throat <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Chest Pain / Discomfort <input type="checkbox"/> Pleuritic Chest Pain <input type="checkbox"/> Chest Trauma <input type="checkbox"/> Feelings of Weakness <input type="checkbox"/> Fainting <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizure(s)	<input type="checkbox"/> Weight Change <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> <i>Causes Awakening</i> <input type="checkbox"/> <i>with Regurgitation</i> <input type="checkbox"/> Calf Tenderness <input type="checkbox"/> Leg Swelling <input type="checkbox"/> Limb Swelling <input type="checkbox"/> Legs feel Restless <input type="checkbox"/> Snoring <input type="checkbox"/> Sleepiness <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep too much <input type="checkbox"/> Insomnia <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Joint Pain / Arthritis <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Fast Heart Rate <input type="checkbox"/> Palpitations <i>Exposure to...</i> <input type="checkbox"/> <i>Asbestos</i> <input type="checkbox"/> <i>Fumes</i> <input type="checkbox"/> <i>Sandblasting</i> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression

Are you here for or do you have a history of Asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you here for Sleep Apnea / Sleep Problems? <input type="checkbox"/> Yes <input type="checkbox"/> No

VACCINATION INFORMATION	
Have you received your FLU vaccine this year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	If yes, date _____
When was your last Pneumonia Shot? Date/Year _____	

ADVANCED SLEEP DISORDER CENTER
 at
 PULMONARY PRACTICE ASSOCIATES
 "Better Sleep, Better Health"
 CPAP CLINIC FOLLOW-UP REPORT

Name _____

DOB _____ BMI _____ Neck Circumference _____ (inches)

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

- 0 = would never doze.
- 1 = would have a SLIGHT CHANCE of dozing.
- 2 = would have a MODERATE CHANCE of dozing.
- 3 = would have a HIGH CHANCE of dozing.

SITUATION:

Likelihood of falling asleep:

CHANCE OF
DOZING

- | | |
|--|-------|
| 1. During the day, after lunch, without alcohol..... | _____ |
| 2. Sitting and reading..... | _____ |
| 3. Watching TV..... | _____ |
| 4. Sitting inactive in a public place (e.g. theater, or in a meeting)..... | _____ |
| 5. Sitting as a passenger in a car for an hour without a break..... | _____ |
| 6. Lying down to rest in the afternoon..... | _____ |
| 7. Sitting and talking to someone..... | _____ |
| 8. In a car while stopped in traffic..... | _____ |
| TOTAL SCORE | _____ |

Answer the questions below ONLY IF you have had CPAP or BiPAP ordered.

1. If you have CPAP, BiPAP, or Oxygen equipment, what company set up your equipment?

2. What is the approximate date you began using your equipment? _____

3. Was the use, cleaning, and care of your equipment explained completely to you by the company? ___YES ___NO

4. Have you had any problems with the company? ___YES ___NO. If YES, explain:

5. If you had CPAP or BiPAP ordered, how many hours a night are you using your equipment?
 _____ Hours per night _____ Days per week

6. If you are not using your equipment as ordered, why not? Explain in detail: _____

7. Do you feel your treatment has improved your quality of life and health? ___YES ___NO
 If yes, how? (check all that apply) ___I have lost weight. ___I have more energy.
 ___I socialize more. ___My overall health is better/feel better.

Comments: _____

Pulmonary Practice Associates - Asthma Assessment Tool
(Only complete if you were previously diagnosed with Asthma)

Pt. Name _____ Date: _____

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done as usual at work, school, or at home?

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> 1
All of
the time | <input type="checkbox"/> 2
Most of
the time | <input type="checkbox"/> 3
Some of
the time | <input type="checkbox"/> 4
A little of
the time | <input type="checkbox"/> 5
None of
the time |
|---|--|--|--|--|

2. During the past 4 weeks, how often have you had shortness of breath?

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> 1
More than
once a day | <input type="checkbox"/> 2
Once
a day | <input type="checkbox"/> 3
3-6 times
a week | <input type="checkbox"/> 4
Once or twice
a week | <input type="checkbox"/> 5
Not
at all |
|--|--|--|--|--|

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> 1
4 or more
nights a week | <input type="checkbox"/> 2
2-3 nights
a week | <input type="checkbox"/> 3
Once or
twice a week | <input type="checkbox"/> 4
Once
a week | <input type="checkbox"/> 5
Not
at all |
|---|---|--|---|--|

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication?

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> 1
3 or more
times per day | <input type="checkbox"/> 2
1 or 2 times
per day | <input type="checkbox"/> 3
2 or 3 times
per week | <input type="checkbox"/> 4
Once a week
or less | <input type="checkbox"/> 5
Not
at all |
|---|--|---|---|--|

5. How would you rate your asthma control during the past 4 weeks?

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> 1
Not controlled
at all | <input type="checkbox"/> 2
Poorly
controlled | <input type="checkbox"/> 3
Somewhat
controlled | <input type="checkbox"/> 4
Well
controlled | <input type="checkbox"/> 5
Completely
controlled |
|---|---|---|---|---|

TOTAL SCORE: _____

Daytime asthma symptoms occur...

- Most days 1 - 2 time a week 1 - 2 times a month Never

Nighttime asthma symptoms...

- disturb sleep cause night waking disturb sleep weekly

- disturb sleep frequently 1 - 2 times a month never disturb sleep