













## Sleep Health MD Notice of Privacy Practices

Effective date, January 1, 2018

This notice describes how your medical information may be used and disclosed (provided to others) and how you can get access to this information. Please review this notice carefully.

This Notice of Privacy Practices explains how Sleep Health MD, its staff members and employees may use and provide your Protected Health Information (called PHI) to others for treatment, payment, and clinical “operations” as described below, and for other purposes allowed or required by law.

### I. OUR PLEDGE:

Sleep Health MD takes the privacy of your health information seriously. We create a record of the care and services you receive to provide quality care to comply with legal requirements. We are required by law to keep your health information private and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep.

### II. WHAT IS “PROTECTED HEALTH INFORMATION” (PHI)?

Protected Health Information (PHI) is information about a patient’s age, race, sex, and other personal health information that may identify the patient. The information relates to the patient’s physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

### III. WHAT DOES “CLINICAL OPERATIONS” INCLUDE?

“Clinical operations” includes activities such as discussions between staff and other health care providers; evaluating and improving quality; reviewing the skills, competence, and performance of staff; training future staff; dealing with insurance companies; carrying out company/employee reviews and auditing; collecting and studying information that could be used in legal cases; and managing business functions.

### IV. HOW IS MEDICAL INFORMATION USED?

Sleep Health MD uses medical records to record health information, to plan care and treatment.

### V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:

Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, and treatment plans).

We will use medical information to plan treatment.

We may disclose Protected Health Information to another provider for treatment (such as referring doctors, and specialists).

We may fill out your requested claims for your insurance company containing medical information.

We may use the emergency contact information you gave us to contact you if the address we have on record is no longer correct.

We may contact you to remind you of your appointment by calling or emailing you.

We may use or disclose medical information about you without your prior authorization for several other reasons.

Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, health oversight audits or inspections and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

We may use or disclose health information about you for research purposes, subject to a special approval process.

### VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you sign the Consent for Release of Information, you are giving Sleep Health MD permission to use and disclose (provide to others) Protected Health Information for treatment, payment, and clinical operations, as described above. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment, or health care operations or as required or permitted by law.

### VII. CAN I CHANGE MY MIND AND WITHDRAW PERMISSION FOR SLEEP HEALTH MD TO DISCLOSE PHI?

You may change your mind and withdraw (revoke) permission, but we cannot take back information that has been released up to that point. All requests to withdraw permission for uses and disclosures of PHI should be made in writing.

## VIII. YOUR PRIVACY RIGHTS

The following explains your rights with respect to your Protected Health Information (called PHI) and a short description of how you may use these rights.

1. You have the right to review and to ask for a copy of your health information. This means that except as explained below, you may review and get a copy of your PHI that is contained in a “designated record set” as long as we keep the PHI. A designated record set contains medical and billing records and any other records that Sleep Health MD uses to make decisions about your care. You may not read or be given a copy of information collected for use in a civil, criminal, or administrative action, or court case; and certain PHI that is protected by law. In some situations, you may have the right to have this decision reviewed. If needed and at your request, Sleep Health MD may provide an electronic copy of your record if Sleep Health MD is able to do so. A fee will be charged for requesting a copy of your records.

2. You have the right to request that access to your health information be limited. This means you may ask us to restrict or limit the medical information we use or disclose for treatment, payment, or clinical operations (described above). Sleep Health MD is not required to agree to a restriction that you ask for. We will tell you if we reject your request. If we do agree to the requested restriction, we will not violate that restriction unless it must be violated to provide emergency treatment.

3. You have the right to request to receive private communications in another way or at other locations.

We will agree to reasonable requests. To carry out the request, we may also ask you for another address or another way to contact you, for example, mailing to a post office box.

4. You have the right to request access and changes to your health information. In most cases, you have the right to look at or get a copy of medical information that we used to make decisions about your care when you submit a written request. You may ask for changes to be made (amended) in PHI about you in a designated record set for as long as we keep this information. We may deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. A request must be submitted in writing.

5. You have the right to receive a record of when your health information has been disclosed by Sleep Health MD.

You have the right to request a record (accounting) of when Sleep Health MD has disclosed your PHI except for uses and disclosures for treatment, payment, and clinical operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

Requests for records about Sleep Health MD’s disclosures of your PHI may not be made for time periods of more than six (6) years or it could be an earlier time period depending upon what the law requires.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

### CHANGES TO THIS NOTICE

We may change our policies at any time. Changes will apply to medical records we already hold, as well as new information after the change occurs. You can receive a copy of the current notice at any time.

### GENETIC INFORMATION DISCRIMINATION ACT (GINA)

SHMD prohibits the use of genetic information. The definition set forth in GINA, defining “genetic information,” with respect to any individual, as (1) the individual’s genetic tests; (2) the genetic tests of the individual’s family members; and (3) the manifestation of a disease or disorder in family members of the individual. “Genetic information,” as defined under both the state and federal law, also includes any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by an individual or family member of the individual.

### BUSINESS ASSOCIATES

The Privacy Rule requires that a covered entity obtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of SHMD. The satisfactory assurances must be in writing, whether in the form of a contract or other agreement between SHMD and the business associate.

### WHAT IF I HAVE A QUESTION OR COMPLAINT?

If you believe your privacy rights have been violated, you may file a complaint by contacting the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint. The address for the U.S. Department of Health and Human Services is:

Office For Civil Rights

US Department of Health and Human Services

Atlanta Federal Center

Suite 3B70

61 Forsyth St., SW

Atlanta, GA 30303-8909

(404) 562-7886 (phone)

(404) 562-7881 (fax) [www.hhs.gov/ocr/hipa](http://www.hhs.gov/ocr/hipa)





# Financial Policy

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Thank you for choosing Sleep Health MD as your healthcare provider. We are committed to your treatment being a successful experience. Our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

## **WE ACCEPT MASTERCARD, VISA, DEBIT CARDS, DISCOVER, CHECKS, MONEY ORDERS AND CASH,**

**Non-Contracted / Indemnity Insurance Plans:** We will bill your insurance company as a courtesy. We require you to pay in full at the time of service. Your insurance company will send payment directly to you.

**Co-Payment –** Your insurance carrier **requires** that all co-payments and deductible amounts be collected at time of service. A billing fee of \$35 will be added to your balance if you do not make your payment at the time of service.

**Referrals -** You are responsible for providing any required referrals or authorizations in advance of your appointment. We will estimate the amount due to the best of our ability.

**Medicare:** - As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co- insurance and we must, by Medicare regulation, collect it. We will be happy to bill your secondary payer as well.

**Secondary Insurers:** - Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

**Divorce Decrees:** - This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult regardless who the policy holder is for the insurance plan(s).

**Missed Appointments:** - There is a \$35 missed appointment fee if you cancel or reschedule a clinic visit appointment with less than 24 hours advance notice or if you fail to arrive for your appointment.

**Sleep Studies:** - Any portion of the fee for sleep studies not covered by your insurance plan is due prior to the performance of the study

**Sleep Study Cancellation or “No-Show”:** - Failure to appear and/or have not cancelled your scheduled study more than 48 hours prior to your study appointment will result in a charge of 10% of the study fee, up to \$400.

**Minor Patients:** - The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

**Your Personal and Insurance Information:** - We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

**Forms:** - There is no charge for forms completed as part of an office visit. There may be a charge for filling out forms based on your medical records when it is not done at the time of an appointment. Fees vary depending upon the form, including school forms, child care forms, immunization cards, disability forms, etc.

**Records and Copying:** - There will be a \$25 charge for copying materials from your chart when done other than at the time of a visit including the transfer of records to another facility.

**Returned Check Fee:** - There is a \$25 banking fee for all returned checks. If your check is returned from the bank, we will no longer accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Patient or Responsible Party

\_\_\_\_\_  
Relationship to Responsible Party



Phone/Text: 844-387-5337  
SleepHealthMD.com

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID: \_\_\_\_\_

Sleep Health MD values your privacy. We also understand that there are circumstances wherein you, our patient, will want or need a person or entity other than yourself to communicate with our office on your behalf. By entering the name of a designee below (spouse, friend, family member, legal representative, etc.), we can aid you in that regard.

Unless and until you have listed a designated person/entity below, we will not be able to allow anyone other than you, the patient, access to any of the three areas listed below. Please update the fields below including the name(s), their relationship to you, and contact information of those you allow access to.

<u>Name of Person/Entity</u>	<u>SCHEDULING</u>	<u>BILLING</u>	<u>MEDICAL DECISION MAKING/ RECORDS</u>
<b>Full name:</b>	<b>YES NO</b>	<b>YES NO</b>	<b>YES NO</b>
Relationship:			
Mobile: Home:			
<b>Full name:</b>	<b>YES NO</b>	<b>YES NO</b>	<b>YES NO</b>
Relationship:			
Mobile: Home:			

I, \_\_\_\_\_, (printed patient name) authorize access by my signature below that the above listed person(s) has my permission to access the indicated areas of my health care.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_

## Sleep Study Pre-Screening Questionnaire

Full Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height & Weight: \_\_\_\_\_

1. Do you have any infectious diseases? Yes  No

If YES, please explain/describe: \_\_\_\_\_

2. Do you make frequent restroom trips during the night? Yes  No  \_\_\_\_\_

3. Do you need assistance getting to the restroom? Yes  No  \_\_\_\_\_

4. Do you use a cane or a wheelchair? Yes  No  \_\_\_\_\_

5. Do you need help in or getting out of bed? Yes  No  \_\_\_\_\_

\*\*Please be aware that the Night Tech won't be able to help you get out of bed. We need to know if you'll need assistance. If you are injured or your mobility is affected, please state below.

\_\_\_\_\_.\*\*\*\*\*

6. Do you speak and understand English? Yes  No  \_\_\_\_\_

7. If mobility or language assistance is needed, you will need to bring a care giver to stay overnight.

Who will be in attendance with you for the evening?

Name/relationship: \_\_\_\_\_

8. For our pediatric patients 16 and under, a parent or legal guardian is **required** to stay overnight. \*\*Optional for patients 17-18\*\* Who will be in attendance with the child for the evening? **Limit 1** person due to space.

Name/relationship: \_\_\_\_\_

9. Do you take sleep medications regularly? Yes  No

If YES, what medication(s) and what dosage? \_\_\_\_\_

10. Are you on supplemental oxygen? Yes  No

11. Are you allergic to medical supplies such as latex or adhesives? Yes  No

If YES, what medical supplies and what is the reaction? \_\_\_\_\_

12. Do you experience panic attacks? Yes  No

13. Are you claustrophobic or have anxiety w/ anything on face or w/small rooms? Yes  No

14. Do you have back problems/pain? Yes  No  If YES, where? \_\_\_\_\_

15. Have you had any recent medical procedures that may affect your comfort in bed? If YES, please explain:

\_\_\_\_\_  
16. What is your normal bed time? \_\_\_\_\_ Normal wake up time? \_\_\_\_\_

17. Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

18. Do you have any questions, comments or concerns about the overnight test?

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## Authorization for Release of Medical Information

**\*This form will be used to obtain medical records from another provider to Sleep Health MD\***

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize Sleep Health MD to obtain my protected health information (PHI) as defined by Federal and State law. I understand that this authorization is voluntary.

The following information may be disclosed to Sleep Health MD:

- Medical Records
- Test Results
- Sleep Studies
- Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*The following section must be completed in full in order to obtain medical records\***

This Health Information may be disclosed by:

Name of the Provider: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that my health care will not be affected if I do not sign this form. This authorization will expire on \_\_\_\_\_ or 5 years from the date of my signature below, whichever is earlier.

I also understand that I may revoke this authorization at any time by notifying Sleep Health MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Sleep Health MD in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient (to the extent minor could not have consented to the care).
- Guardian or conservator of an incompetent patient.
- Beneficiary or personal representative of deceased patient.

web: [www.sleephealthmd.com](http://www.sleephealthmd.com) phone: 844-387-5337 fax: 866-264-3890

**Santa Cruz**  
1665 Dominican Way # 222  
Santa Cruz, CA 95065

**Watsonville**  
150 Carnation Dr. #4  
Freedom, CA 95019

**Monterey**  
101 Wilson Road #D  
Monterey, CA 93940

**Sunnyvale**  
260 S Sunnyvale Ave #6  
Sunnyvale, CA 94086