CENTER FOR
SLEEP & NASAL SINUS
DISORDERS

Thank you for choosing our clinic.

At Center for Sleep and Nasal Sinus Disorders, our goal is to provide the highest possible level of care in a site of service model. Please bring your ID and insurance cards to your appointment. It will be very helpful if you can bring a list of current medications. If you are on CPAP bring a compliance download from your CPAP machine which you can obtain from the company from whom you obtained your machine. Please arrive 15-20 min prior to your scheduled appointment time to complete new patient registration and check in. It is our goal to begin the evaluation with one of our nurses or medical assistants as close to your appointment time as possible and soon thereafter, to meet with our physician.

If you have insurance coverage be sure to bring your insurance cards with you for every appointment. Please check to confirm if your insurance requires a referral from your primary care physician. As a reminder, insurances companies may not cover all of the procedures or services available in our office. While we are contracted with many insurance plans in the area, we are not in all plans. Please confirm with your insurance plan that we are in "network".

If your insurance has a co-pay, expect this to be paid at the time service.

If you do not have insurance coverage, payment in full of $172.50 is due at the time of the visit. This reflects a 25% discount for cash pay.

Depending on the complexity of your medical needs and the other tests and procedures which may need to be done, your visit may take more than an hour. Please schedule your day accordingly as we endeavor to save you time and cost by completing as many components of your care as possible in one visit.

Unfortunately, if you are late for your scheduled arrival time, your appointment may have to be rescheduled. This will help to serve you better and in a timely manner. If for any reason you are unable to keep your appointment or need to make a change, please contact our office at 574-500-2010. Kindly give us at least 24 hours notice.

Thank you for trusting us with your sleep and nasal sinus needs. We look forward to seeing you.

Sincerely,

The Staff at Center for Sleep and Nasal Sinus Disorders

2012 S. Main St. Suite B
Goshen, IN 46526
Phone (574) 500-2010

53760 Generations Dr
South Bend, IN 46635
Phone (574) 500-2010

Center for Sleep and Nasal Sinus Disorders

Last Name_____ First Name_____ MI _____

Male ___ Female ___ Date of Birth_____ Age _____ Height _____ Weight _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

Preferred Method of Contact: Home ____ Cell ____ Text Message ____ Emails ____

May we text appointment reminders: Yes ____ No ____ Primary Language: English ____ Other _____

Race: White ____ African American ____ Other _____ Declined ____

Marital Status: Single ____ Married ____ Divorced ____ Widowed/Widower ____

Primary (Family) Physician _____ City_____

Referring Physician _____ City_____

Dentist _____ City _____

Emergency Contact _____ Phone Number _____ Relationship _____

Preferred Pharmacy and Address_____

Parent(s)/Guardian Responsible Party Information

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Phone Number _____ Relationship to patient_____

Primary Insurance information

Name of Policy Holder (as it appears on insurance card) _____

Date of Birth _____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

Insurance Co_____ Policy/ID#_____ Group#_____

Secondary Insurance Information

Name of Policy Holder (as it reads on insurance card) _____

Date of Birth _____ Relationship to Patient_____

Address_____ City_____ State____ Zip_____

Insurance Co_____ Policy/ID#_____ Group#_____

Patient Name _____

Reason for Today's Visit _____

Allergies (medications and non-medications)

_____

_____

Current Medications (this includes prescriptions, over-the-counter, vitamins, and herbal medications)

Name of Medication	Dosage	Frequency

Surgeries (please include the name and date of surgery)

_____

_____

_____

Have you ever had any problems with anesthesia? Yes_____ No____

In the past year have you had any of the following

Mammogram: Yes ____ No____ Date _____ Colonoscopy: Yes____ No____ Date _____

Flu Vaccine: Yes____ No____ Date _____ Covid Vaccine: Yes____ No ____ Date _____

HIPAA Privacy Release: I authorize the release of my medical/appointment information to: _____ (initials)

Name_____ Relationship_____ Phone Number_____

Name_____ Relationship_____ Phone Number_____

As required by the HIPAA Privacy Regulations, all patients who receive health care services in our office must:

Have the right to review or receive a copy of the "Notice of Privacy Practices" form and how our office will use and disclose your medical information for legitimate business purposes only. This document is attached. Please sign to acknowledge that you have received this.

X_____

Out of Network Referral Notice _____ (initials)

We may find it necessary to refer you for services with another provider for input or treatment of your condition(s). While we try to select the most appropriate provider to refer you to, some providers may be in-network while others may be out-of-network with your insurance plan. It is your responsibility to contact your insurance provider to confirm if a provider is in-network before receiving healthcare items or services.

Consent to Access External Medication History _____ (initials)

By signing this form Center for Sleep and Nasal Sinus Disorders may pull my external medication history from pharmacies. I understand that all prescriptions prescribed elsewhere and by other doctors will by electronically entered into my chart.

Automated Calls _____ (initials)

I authorize Center for Sleep and Nasal Sinus Disorders or any outside agency to contact me regarding my patient balance.

Assignment and Release

I certify that I, and/or my dependents(s) have insurance coverage with the above-named insurance company(ies) and assign my insurance benefits to be paid directly to the healthcare provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical or other information required to process my insurance claim(s).

_____

Patient's Name

X_____ _____

Signature of patient/guardian/personal representative Date

CENTER FOR
SLEEP & NASAL SINUS
DISORDERS

Patient Financial Summary

Center for Sleep and Nasal Sinus Disorders (CSNSD) is committed to providing you with the best care possible. While clinical care is the focus of our relationship with you, we also recognize that financially paying for care involves complicated and sometimes burdensome circumstances. While we aim to be understanding and flexible, we are required to adhere to specific billing requirements. We commit to helping you understand your financial options with our clinic. If you have any questions please call the practice manager at (574) 500-2010.

Payment options:

- Cash, credit card or check payments made in person, by mail, over the phone, online or via the patient portal
- Payment plans

Statements will be sent after the insurance payments have been confirmed. It is your responsibility to pay the amounts due or arrange a payment option with CSNSD. A $30 fee will be charged if a check is returned for insufficient funds.

Insurance payments and patient responsibilities:

Our clinic will bill your insurance as a courtesy on your behalf. It is your responsibility to verify and complete the following or you may be responsible for the full costs of your services.

- Bring your insurance card to every visit.
- Correct inaccuracies or missing insurance plan information that may prevent us from billing.
- Pay copayments, deductibles and co-insurances as required by your insurance plan.
- Confirm whether or not a service is covered by your insurance plan.
- Obtain a referral or authorization if required by insurance.
- Verify whether or not Dr. Douglas Liepert is in or out of network for your plan and how this impacts coverage and payment of your services.
- Pay down payments or prior balances as indicated by the practice.

A decision to proceed with services without the appropriate referral, authorization, network participation or insurance coverage may result in a balance due on your account.

Patients without insurance coverage:

CSNSD will provide a 25% discount to patients who do not have insurance or who wish to receive services not covered by their insurance plan. Payment is due at the time of service. There is a $100 non-refundable fee for scheduling an appointment for cash pay patients. This will be applied to the visit charge. CSNSD will collect 50% of cost of surgery at least 2 weeks prior to the procedure.

Payment Plans:

CSNSD offers the following payment plans. If a payment plan is not selected by calling the clinic manager within 30 days of receiving your initial statement, no payment plan will be offered.

- <$100 Must be paid immediately
- $100 - $199 Must be paid within 2 months
- $200 - $499 Must be paid within 4 months
- $500 - $899 Must be paid within 6 months
- >$900 Must be paid within 9 months

No-show: There is a $30 no-show fee if more than 24 hours notice is not given for appointment cancellation/reschedule.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Center for Sleep and Nasal Sinus Disorders

Appointment Policy

To our valued patients,

Our goal at Center for Sleep and Nasal Sinus Disorders is to provide exceptional services to our patients. In order to serve you better we request at least **24-hour notification** of canceling or re-scheduling an appointment you have made with us. If you will be arriving past your scheduled appointment time, a courtesy call is appreciated so we do not consider it a no-show appointment.

It is our policy that if do not show up for your appointment we will require a **fee of $30.00** to be paid prior to another appointment being made.

We appreciate your understanding of our administrative necessities in order to serve our patients with excellence.

Facility Ownership Policy

Doctors are required by Indiana law to advise you when they have ownership interest in some of the facilities or services recommended for your care. Your doctor believes these are the most appropriate choices for the delivery of your healthcare. Our Provider has ownership interest in Allied Physicians Surgery Center PC.

You may request an alternate facility or service other than the entity your provider has recommended. Requests for an alternate facility should be discussed with your provider or the practice staff to understand the service or financial impact of this decision.

I have read and understand the above statements.

_____

Patient Name

X_____ **_____**

Signature Date

Notice of Non-Discrimination

Discrimination is against the law. Center for Sleep and Nasal Sinus Disorders complies with applicable federal and civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Center for Sleep and Nasal Sinus Disorders provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters

- Written information in other formats

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, please let us know.

If you believe that Center for Sleep And Nasal Sinus Disorders has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail to Center for Sleep and Nasal Sinus Disorders, 2012 S. Main St. Suite B, Goshen, IN 46526.

If you need help filing a grievance, our Clinical manager is available to help you. 574-500-2010.

You can also file a civil rights complaint with the U.S Department of Health and Human Services, Office of Civil Rights, electronically through the Office for civil rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S Department of Health and Human Services 200 independence Avenue SW Room 509F, HHH Building Washington, D.C 20201, Phone 1-800-358-1019, 800537-7679 (TDD). Complaint forms at available at http://www.hhs.gov/ocr/office/file/index.html.

Center for Sleep and Nasal Sinus Disorder

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the
Health Insurance Portability and Accountability Act of 1994 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and what relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without you authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse, or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Sect 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of an changes. You then have the right to object or withdraw as provided in this notice.
Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filling a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak to our manager.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.