Best Health Sleep Center

Welcome Letter

RE: Overnight Sleep Study

Dear Patient:

Your referring physician has arranged for a sleep evaluation with our ***Sleep Center***, please select the correct center. We are excited to serve you our team consists of highly professional, dedicated Technicians, Care Coordinators and Physicians.

Please fill out the attached paperwork prior to your scheduled appointment.
If this is your first sleep study at our facility, please complete the entire package. Please remember to bring your completed "Sleep Questionnaire" with you to your appointment. You can also do online. Also, if you were provided a prescription from referring physician, please bring with you as well.

In addition, please remember to bring your Insurance Card and a Photo ID, as well. Please bring an insurance referral from your Primary Care Physician, if your insurance requires that you do so for a specialist.

Please do not arrive earlier than your scheduled appointment time, as the technologist will not be available or ready until then.

We look forward to serving you and hope to accommodate you in a most courteous and professional manner.
If we may provide any additional information, please call us at **866 938 9996 or fax 8663243957**

Sincerely,

Patient care Coordinator
Best Health Sleep Center

Best Health Sleep Center

Locations Check Any

Maryland

▭ National Harbor Sleep Center

6357 Oxon Hill Road
Oxon Hill MD 29745 Ph 866 938 9996, Fax 866 324 3957

▭ Laurel Sleep Center

13938 Baltimore Avenue
Laurel MD 20707, Phone: 866 938 9996, Fax 866 324 3957

▭ Montgomery Sleep Center

2415 Musgrove Road, Silver Spring MD 20904
PHONE: 301 989 0193, Fax 301 879 2325

VIRGINIA

▭ Dumfries Sleep Center

3763 Fettler Park Drive, Dumfries VA 22025
1 571 931 6012, Fax: 1 571 931 6065

▭ Annandale

3301 Woodburn Rd, Ste 304 , Annandale, VA 22003
Phone: 866 938 9996, Fax 866 324 3957

▭ Culpeper Sleep Center

246 E Davis St, Suite 100, Culpeper VA 22701
Phone: 540 825 7140, Fax : 540 825 7141

▭ Alexandria/Mt Vernon Sleep wellness

8101 Hinson Farm Road Suite 201,Alexandria, VA 22306 Suite 201,
Phone: 703 888 3036, Fax: 703 888 3175

▭ South Hill Sleep Center

518 W. Atlantic Street, Suite B, South Hill 23970
Ph 1 434 584 0055, Fax 1 434 584 0054

▭ Hopewell Sleep Center

406 N 6th Avenue, Hopewell VA 23860
Phone 804 344 0842, Fax 540 693 2586

☐ Home Study Any Location MD or VA

Best Health Sleep Center

LATEX ALLERGY- PATIENT QUESTIONNAIRE

Patient Name: _____

		Yes	No
1.	Have you ever had allergies, asthma, hay fever, eczema or problems with rashes?	❑	❑
2.	Have you ever had anaphylaxis or an unexplained reaction during a medical procedure?	❑	❑
3.	Have you ever had swelling, itching or hives on your lips or around your mouth after blowing up a balloon?	❑	❑
4.	Have you ever had swelling, itching or hives on your lips or around your mouth during or after a dental examination or procedure?	❑	❑
5.	Have you ever had swelling, itching or hives following a vaginal or rectal examination or after contact with a diaphragm or condom?	❑	❑
6.	Have you ever had swelling, itching or hives on your hands during or within one hour after wearing rubber gloves?	❑	❑
7.	Have you ever had a rash on your hands that lasted longer than one week?	❑	❑
8.	Have you ever had swelling, itching or hives after being examined by someone wearing rubber or latex gloves?	❑	❑
9.	Have you ever had swelling, itching or hives, running nose, eye irritation, wheezing or asthma after contact with any latex or rubber product?	❑	❑
10.	Has a physician every told you that you have rubber or latex allergy?	❑	❑
11.	Are you allergic to bananas, avocados, chestnuts, pears, fig, papaya or passion fruit?	❑	❑
12.	Are you presently on beta blockers?	❑	❑

Signature: _____ Date: _____

Best Health Sleep Center

NO SHOW ---- CANCELLATION --- LATE FEE POLICY

There is a **$200.00**charge for appointments that are not kept or cancelled with less than a 24 hour notice before your scheduled sleep study appointment. If you show up late for your scheduled appointment, you may be turned away and be charged as well. Please contact us at (703) 204-0355 should the need arise.

Your health insurance will **NOT** pay for this fee. You will be the responsible party.

This policy is instituted as part of our sleep center's goal to provide superior care for our valued patients. We have many patients in need of sleep testing and a highly qualified sleep technologist is scheduled in advance for your specified sleep testing needs. *It is essential that you let us know immediately if you are unable to keep your appointment.*

Your signature below acknowledges that you have received notice of this policy and will be responsible for canceling in advance as well as any charges resulting from non-compliance to this policy.

_____ _____

Patient Date

_____ _____

Witness By: Date

Best Health Sleep Center

PATIENT REGISTRATION FORM

PATIENT NAME LAST	FIRST	MIDDLE		DATE OF BIRTH
HOME ADDRESS	APT. NO.	CITY	STATE	ZIP CODE
OCCUPATION ☐ EMPLOYED ☐ RETIRED ☐ STUDENT	SOCIAL SECURITY #	MARITAL STATUS ☐S ☐M ☐D ☐W	SEX ☐M ☐F	HOME PHONE
EMPLOYER	E – MAIL ADDRESS			WORK PHONE
				CELL #
SPOUSE (OR PARENT) NAME	SPOUSE (OR PARENT) EMPLOYER			SPOUSE / PARENT WORK PHONE:
EMERGENCY CONTACT:			EMERGENCY CONTACT PHONE:	

PRIMARY INSURANCE INFORMATION

SUBCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH
PRIMARY INSURANCE COMPANY NAME		SOCIAL SECURITY # SPOUSE:	
ADDRESS			
CITY	STATE	ZIP	
ID OR POLICY #	GROUP / CODE	EFFECTIVE DATE	

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	
SECONDARY INSURANCE NAME POLICY	☐ SPOUSE OR ☐ INDIVIDUAL	ID OR POLICY #	GROUP OR CODE #
ADDRESS			
CITY	STATE	ZIP	

PATIENT AUTHORIZATION

I, _____, hereby authorize SAH Consulting, Inc. to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or _____ Insurance Company, be made directly to the above-
(Name of other insurance company)
named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).

I certify that the information I have reported with regarded to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician / supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.
(Name of Medigap Carrier)

_____ _____

DATE SIGNATURE OF SUBSCRIBER OR BENEFICIARY

Best Health Sleep Center

Sleep Disorders Screening Tool
Health Risk Assessment - Adult

SLEEP HISTORY

Height: ____ft. ____in. Weight: _____lbs. Weight gain / loss in the past 2 years: _____lbs.

Blood Pressure_____

Main Sleep Complaint/Reason for night-time awakenings:

_____

_____

_____

At what age did this problem begin? _____ years old
How does this affect your life and daily activities?

_____

_____

Have you had any previous evaluations, examinations or treatment for this sleep problem or any other problem with your sleep? Yes _____ No _____ If yes, briefly describe the evaluation, treatment and results, including medication.

If employed, what are your usual working hours? Start time _____ Stop time _____
What time do you usually go to bed and get up on weekdays (or work days)? _____ to bed _____ get up
What time do you usually go to bed and get up on weekends (or days off)? _____ to bed _____ get up

Section 1 — Insomnia

Yes	No	
☐	☐	Do you have trouble falling asleep?
☐	☐	Are you bothered by thoughts that keep you from sleeping?
☐	☐	Are you frightened to go to sleep?
☐	☐	Do you feel depressed or sad?
☐	☐	Does it take you more than a half hour to fall asleep?
☐	☐	Do you awaken much earlier in the morning and are unable to fall back to sleep?

Section 2 — Sleep Apnea

Yes	No	
☐	☐	Do you often feel that you get too little sleep at night?
☐	☐	Are you bothered by sleepy periods during the day?
☐	☐	Do you remember dreaming?
☐	☐	Do you snore, or has someone told you that you snore?
☐	☐	Does the snoring disturb your bed partner or someone else in the house?
☐	☐	Are you bothered by nightmares?

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Yes	No	
☐	☐	Do you have unusual behavior during sleep?
☐	☐	Do you usually feel tired or sleepy during the day?
☐	☐	Do you have high blood pressure?
☐	☐	Have you been gaining weight?
☐	☐	Have you been undergoing changes in your personality?
☐	☐	Do you sweat during the night?
☐	☐	Do you feel you have lost interest in sex?
☐	☐	Do you waken gasping for breath in the middle of the night?
☐	☐	Do you have headaches in the morning?
☐	☐	When you have a cold do you find falling asleep more difficult?
☐	☐	Have you ever felt your heart pounding or beating irregularly during the night?
☐	☐	Have you been told that your performance on the job is not up to par?

Section 3 — Narcolepsy

Yes	No	
☐	☐	Do you have difficulty concentrating at school or at work?
☐	☐	Have you fallen asleep at the wheel of a car?
☐	☐	Do you fall asleep during the day?
☐	☐	Have you ever fallen asleep while laughing or crying?
☐	☐	Do your knees get weak if you laugh or get angry?
☐	☐	Have you fallen asleep during physical exertion?
☐	☐	During the day, do you feel dazed as if in a fog?
☐	☐	If you become angry, does your body feel limp?
☐	☐	While falling asleep or awakening, have you experienced vivid dreams?
☐	☐	Soon after falling asleep, have you had nightmares?
☐	☐	Do you often feel that you must fill your day with activity?
☐	☐	No matter how hard you try to stay awake, do you still fall asleep?

Section 4 — GERD

Yes	No	
☐	☐	Do you gasp for breath during the night?
☐	☐	Do you awaken in the night coughing?
☐	☐	Are you hoarse in the morning?
☐	☐	Do you awaken with heartburn?
☐	☐	Do you have a chronic cough?
☐	☐	Are you taking antacids routinely on a weekly basis?
☐	☐	Do you have frequent sore throats?

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Section 5 — Restless Legs/PLMS

Yes	No	
☐	☐	Do you have pain that interferes with your sleep?
☐	☐	Do you awaken with muscle aches?
☐	☐	Do you have muscle tension in your legs, even outside of exercise?
☐	☐	Do you kick in bed at night?
☐	☐	Even though you sleep at night, do you awaken feeling tired?
☐	☐	Have you experienced a sensation of "crawling" or aching in your legs?
☐	☐	At night, do you feel the need to move your legs?

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How likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently try to estimate the effect it might have on your level of drowsiness. Use the following scale to choose the most appropriate number for each situation.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (in a meeting or watching a movie)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

Have you been told or do you have any of the following?

Problem	Yes	Time/Wk.	Age of onset	Last occurred
a. Talk while asleep				
b. Walk while asleep				
c. Grit teeth while asleep				
d. Wake up screaming or afraid for no reason				
e. Stop breathing in your sleep				
f. Awaken with heartburn or sour taste				
g. other_____				

Does anyone in your family have any sleep problems? Yes _____ No _____

If yes, briefly describe and give their relationship to you _____

PAST MEDICAL HISTORY

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Please list any medical problems, past or present.

	Yes	Type of Problem	Dates	Physician, Clinic or Hospital
Thyroid				
Last blood test for thyroid				
Eyes,ears,nose,mouth, throat				
Heart, circulation (including blood pressure)				
Head, nervous				
Breathing (lungs)				
Stomach, digestive				
Urine, kidney				
Sexual				
Bones, joints, arms, joints				
Diabetes, glands				
Weight problems				
Mental health				
Other				

Have you had any of the following:

Surgery	Yes	No	If yes, when?
Tonsillectomy			
Adenoidectomy			
Nasal or sinus surgery			
Vocal cord surgery			
Other surgery			

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- If you use any prescription or over the counter medications regularly or occasionally? Yes _____ No _____

If yes, please list by name below:

List all medications (OTC, minerals, herbals, supplements, weight loss aids).					
Medication Name	Dose	How Often	How Long	Reason	Prescribing Doctor

For each of the beverages listed, write the average number you drink per day:
Regular coffee _____ cups/day decaffeinated coffee _____cups/day
Tea _____ cups/day caffeinated soft drinks _____cups/day

On the average, how many alcoholic beverages do you drink a week? _____

On the average, how much tobacco do you smoke? (Please fill in number per day).
Cigarettes _____ Cigars _____ Pipe _____ Chewing Tobacco_____

Do you get regular exercise? Yes_____ No _____
What kind _____ How often_____ Time of day _____

Best Health Sleep Center

AUTHORIZATION AND CONSENT FOHM FOR SLEEP DISORDERS TESTING

I,_____, hereby authorize (a) Best Health Sleep Center (the "Center") and its employees and (b) ——————————' M.D. (the "Attending Physician") and any assistants or other personnel under his or her supervision to administer or arrange for the administration described below (the "Procedure") and any other unforeseen diagnostic or therapeutic procedures that in his or her judgment are advisable due to conditions that may develop during the procedure.

Polysomnography (PSG),Continuous Positive Airway Pressure (CPAP) Bi LcveL Positive Airway Pressure (BiPAP), Home studies, Multiple Sleep Latency Test (MSLT), MWT(Multiple Wakefulness Testing), Pap Naps, Oral device Studies, Actigraphy

I understand that this pprocedure has been recommended in order to evaluate my sleep patterns and any sleep-disordered breathing that may disrupt normal sleep patterns. The procedure will measure physiological aspects of sleep. A number of activities are measured during a sleep study, such as electrical activity of the brain and heart, oxygen saturation, chin tone and leg muscle movement. For most polysomnogram studies, you will need to spend at least 6 hours overnight in the sleep Lab.

I u understand that the procedure re will consist of the following :

Polysomnography (PSG)

For a polysomnogram (PSG) study, small metal discs and medical stickers called electrodes will be placed on the head and body with a small amount of paste and gauze. The electrodes will record brain activily, eye movement, oxygen levels, heart rate and rhythm, breathing rate and rhythm, the flow of air through the mouth and nose, snoring, body muscle movements, and chest and belly movement. Soft elastic belts will be placed around your chest and be!Jy to measure breathing. l3Jood oxygen levels will be checked by a small pulse oximeter placed on the Up of your finger. When the study begins you will be monitored throughout the study by a technician and video cameras. After the study is completed , the results are tabulated and may be sent to the physician or other health professional that referred you to the sleep center.

Contiuous Positive Airway Pressure (CPAP) /Bilevel Positive Airway Pressure (BiPAP):

If diagnosed with sleep apnea, you may be scheduled to wear a mask that is connected to a continuous positive airway pressure (CPAP) machine for a second study. You will have the same electrodes placed on your body that were required during the polysomnogram with the addition of a CPAP mask. The mask fits over your nose or inside of your nostrils. The CPAP machine delivers a constant stream of filtered room air via the mask .in order to ma.intain your airway and eliminate any type of sleep disordered breathing. On occasion the addition of supplemental oxygen with the CPAP or BiPAP is required to maintain oxygen levels within a normal range (greater than 90%). Unlike continuous positive airway Pressure (CPAP), BiPAP uses an alternating pressure to maintain the airway and eliminate sleep disordered breathing and provides two different pressures, a higher one during inhalation and a lower pressure during exhalation. You will have an opportunity to become acclimated to the CPAP/BiPAP device prior to the start of lhe study.

- **Multiple Sleep Latency Test (MSLT):**

During the MSLT test, naps will be taken at various times during the day beginning the morning after a night time sleep test. Between naps, you must try to stay awake. The amount of time it takes to fall asleep for the naps and the sleep patterns during the naps will be recorded using electrodes that monitor brainwaves and the heart.

- **Multiple Wakefulness Test (MWT):**

morning after a good night time sleep . Between naps, you must try to stay awake. The amount of time it takes to fall asleep for the naps and the sleep patterns during the naps will be recorded using electrodes that monitor brainwaves and the heart.

Home Studies done if indicated, Patients with a high pre-test probability of moderate to severe OSA. Patients with no significant co-morbid medical condition. Examples of co-morbid conditions include moderate-severe pulmonary diseases (cystic fibrosis, pulmonary fibrosis, active asthma, COPD), congestive heart failure and neuromuscular diseases (ALS, multiple sclerosis, Parkinson's disease).Patients suspected of having no co-morbid sleep disorder other than OSA. Patients unable to be studied in a sleep laboratory. To monitor response to non-PAP treatments after the diagnosis has already been made. BMI less than 35. Age 18-65.

Pap Naps done during day in the presence of technician to get familiar with Desensitization of mask and equipment.

Oral Devices Are used if has no gum infection, loose dentures, no TMG can be temporary or permanent, we will test if effective and recommend seeing dentist. Recommend doing study to see effectiveness.

Actigraphy done to document circadian rhythm issues, involves wearing a wrist device monitors activity or movement.

Best Health Sleep Center

AUTHORIZATION AND CONSENT FORM FOR SLEEP DISORDERS TESTING

I understand that during the procedure there exists the possibility of certain risks, including without limitation, m y ski n ma y be red or itchy from the tape or paste used with the electrodes. Every effort will be made to minimize these risks. In addition, emergency equipment and trained personnel are available to deal with unusual situations that may arise.

I understand that the information obtained from the procedure will be treated as privileged and confidential and I hereby authorize the center to release any information acquired during the procedure to the attending physician, my treating physician, my insurance company, any other physician providing for my care or as per mi t ted under federal or state privacy laws. I also understand that the information obtained from the procedure ma y be used for statistical a n d/or scientific purposes as permit ted by federal and state privacy laws.

I understand that the attending physician and my treating physician will receive a report of the results of the procedure, and that I should direct any quest ions I have regarding the results of the procedure to my treating physician.

I hereby acknowledge the following:

1. **I have discussed the procedure and associated risks with my treating physician;**
2. **I have been fully advised of the alternative treatments available to me and the consequences t hereof;**
3. **I a m aware of the risks associated with forgoing the procedure;**
4. **l have been given the opportunity to ask questions about the procedure and all of my questio ns have been answered to my satisfaction; and**
5. **No guarantees or assurances have been made to me concerning the results of the procedure.**

BY SIGN[NG BELOW, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM AND I GIVE MY AUTHORIZATION AND CONSENJ AS DESCRIBED ABOVE.

_____

PATIENT SIGNATURE DATE

_____

PATIENT REPRESENTATIV E SIGNATURE* DATE

_____

WITNESS SIGNATURE . DATE

* Please explain representative's relationship to the patient and include a description of representative's authority to act on behalf of the patient:

_____

_____

_____

Best Health Sleep Center

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.

This practice understands that medical information about you and your health is personal. We are committed to protecting this information. This practice will create a record of the care and services you receive as a basis for planning your care andtreatment, for communicating with the many healthcare professionals involved in your care, to _obtain payment for services provided, as a source of information for public health officials, and to provide you with quality care while complying with certain legal requirements.

By law, this office is required to provide you with our Notice of Privacy Practices. If you should have any questions about this Notice or to submit requests pursuant to this Notice, please contact the Practice Manager at 703-204-0355. A copy of this Notice is available upon request.

METHODS MEDICAL INFORMATION MAY BE USED AND DISCLOSED

The following information describes different ways this office may use and disclose your medical information. Althoughexamples are given, it is impossible to list every use or disclosure.

For treatment we are permitted to use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management with other physicians or facilities. For example, the physicians in this practice are specialists. When we provide treatment, we may request information from your referring physician as well as provide information about your diagnosis and treatment so that he may appropriately treat you for other medical conditions.

Par Payment We may use and disclose ·information about you to bill and collect payment for services provided to you from your insurance company, Medicare, you, or other payer. For example, we may need to disclose information about you to a health plan in order for the health plan to pay your physician for the services you received. We may also need to inform your health plan about a treatment or procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover theseservices.

For Health Care Operations We are permitted to use and disclose medical information about you in order to efficiently operate our office and ensure all patients receive quality care. For example, your medical records or health information may be used to evaluate health care services, and the quality of your treatment. In addition, medical and billing records are audited to ensure we maintain our compliance with federal and state regulations.

Appointment Reminders and Other Health Related Benefits We may use and disclose medical information about you as a reminder of an upcoming appointment, or to inform you of treatment alternatives or other health related benefits. For example, we may provide a reminder of your next appointment by telephone, voicemail/answering machine, or written notice.

Research or Other Qualified Personnel We may use and disclose medical information about you for research or for management audit, financial audit, or program evaluation. You will not be directly or indirectly identified in any report of the research, audit, or evaluation. Your identity will not be disclosed in any manner.

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Organ and Tissue Transplants If you have formally indicated your desire to be an organ donor or recipient, we may release medical information to organizations who handle procurement of organ, eye, or tissue transpla ntation.

Coroners, Medical Examiners, and Funeral Directors We are perm:tted to release information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release information to funeral directors in. order for the director to carry out his duties.

Military, Veterans, and National Security If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose your medical information for specialized governmental functions, authorized national security and intelligence activities, and for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

As Required by Law We will disclose medical information about you when required by federal or Virginia law or regulations.

Public Health Risks and Health Oversight We may disclose your medical information for public health activities which may include the prevention or control of disease, injury or disability, to report births and deaths, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your information to report reactions to medications or problems with products, or to notify individuals of recalls of product they may be using.

Medical information about you may be disclosed to health oversight agencies for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. They may include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor government programs, eligibility or compliance, and to enforce civil rights and criminal laws.

Abuse or Neglect We will disclose medical information in order to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. Virginia law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report the abuse or neglect of elders or the disabled.

Worker's Compensation Medical information about you may be disclosed to provide benefits to you for work-related injuries or illnesses.

Lawsuits and Disputes If you are involved in certain lawsuits or administrative disputes, we are permitted to disclose medical information about you in response to a court order or administrative order.

Law Enforcement If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided the information:

Is in response to a court order, warrant, or subpoena;

Pertains to a victim of crime, whether living or deceased, and we are unable to obtain the person's agreement; Is released

because a crime has occurred on these premises;

Is released to locate a fugitive, missing person, or suspect.

We may also release medical information about you when necessary to prevent a serious threat to your health and safety, including mental and emotional injury to you, or the health and safety of the public or another person.

Inmates If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional facility or law enforcement official. This release is permitted to allow the institution to provide you with medical treatment, to protect your health or the health and safety of others, or for the safety or security of the correctional facility.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

Best Health Sleep Center

The U.S. Department of Health and Human Services created regulations intended to protect your rights as a patient as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following are rights regarding your medical information, which this office collects and maintains. We will not retaliate against a patient who exercises their rights under HIPAA.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information this office uses or discloses about your treatment, payment or health care operations. You also have the right to request a limit on themedical information disclosed to someone who is not involved in your care or the payment for your care. We are not requiredto agree to your request. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions you must make your request in writing to the Practice Manager. Include the following in your request: (1) what information you want to limit; (2) what kind of restriction you are requesting; (3) to whom the limits apply. For example, you may request we limit disclosure to your spouse, family members or other relatives, or close personal friends who may or may not be involved in your care.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask to be contacted only at work or by mail. This request must be made in writing and submitted to the Practice Manager. We are required to accommodate only reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Practice Manager. We may refuse to provide you with certain information you request to inspect or copy if the information:

Includes psychotherapy notes;

Has been compiled in anticipation for use in civil, criminal, or administrative proceedings; Is subject to

or exempt from the Clinical Laboratory Improvements Amendments of 1988; Identifies a person whom

information was obtained under a promise of confidentiality.

If you request a copy of your medical information, we are permitted to charge a fee. The Virginia State Board of Medical Examiners has established these fees for the costs of copying, mailing, or summarizing your records. Virginia law requires we provide these copies or a narrative within 15 days of your request. We will inform you of when the records will be ready or ifwe believe access should be limited or denied. If access is denied, we will notify you in writing of this decision.

We may deny your request to inspect and copy records in certain limited circumstances. If you are denied access to medical information, including psychotherapy notes, you may request this denial be reviewed. Another licensed health care professional who was not involved in the original decision to deny access will perform this review.

Right to Amend You have the right to request an amendment of your medical information for as long as the information is maintained by this office. To request an amendment, you must submit your request in writing along with a reason that supports your request to the Pract'1ce Manager.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

Was not created by this office, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the medical information kept by thisoffice;

Best Health Sleep Center

Is part of the information you would not be permitted to inspect or copy; Is accurate and complete.

We will respond to your request in writing within 60 days. However, if we refuse to allow an amendment, you are permitted to include a statement about the information in your medical record. If your amendment is accepted, we will work with you to notify other designated individuals of this amendment.

Right to an Accounting of Disclosures You have the right to request an accounting of disclosures. This *is* a list of disclosures made of your medical information for purposes other than treatment, payment, or health care operations, or disclosures made per a signed authorization by you or your representative. Other limitations may apply as well.

You must submit your request in writing to the Practice Manager. The first accounting of disclosures within any 12-month period will be free of charge. We are permitted to charge a reasonable fee for any additional requests within that same period. You will be notified of the cost involved so that you may withdraw or modify your request before any charge is incurred.

Complaints If you believe your privacy rights have been violated, you may file a complaint with the Practice Manager. You may also send written complaints to the Office for Civil Rights, U.S. Department of Health and Human Services.

Changes to Our Notice. This office reserves the right to change our practices, policies, and procedures and to make the new provisions effective for all protected health information we maintain. Should any change be made, a revised Notice of Privacy Practices will be posted in the office, and made available to you upon your request. This Notice of Privacy Practices is effective April 14, 2003.

We strive to provide quality healthcare to ***all our patients.***

Signature of Patient or Representative	Relationship/Authority or Represenlalive	Dale
Witness	Dale	

HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

****1. Authorization****

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other/treating Providers list_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] SMS/Email_____

The best time to reach me is (*day*)_____ between (*time*)_____

Persons not Authorized if any_____

****2. Effective Period****

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

****3. Extent of Authorization****

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception

of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date