National Sleep Solutions Inc.

Sleep Specialist

PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Social Security (SS) #:	Date of Birth (DOB):	Gender: □ M □ F
Mailing Address:		
Home / Work Phone:	Cell Phone:	
E-mail Address:	Marital Status: □ Single □ Married □ Other	
Employed: □ Full Time □ Part Time □ Retired	Employer:	
Relationship to Responsible Party / Insurance Policy Holder: □ Self □ Spouse □ Parent □ Child □ Other		

INSURANCE INFORMATION	
Primary Insurance	Secondary Insurance
Insurance Company:	Insurance Company:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policy Holder:	Policy Holder:
Policy Holder SS#: DOB:	Policy Holder SS#: DOB:
Policy Holder Employer:	Policy Holder Employer:

CONTACTS		
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:		Phone:
Referring Physician:		Phone:

By signing this form,

- I authorize National Sleep Solutions to provide medical care as necessary for me.
- I acknowledge receipt of National Sleep Solutions Office Policies, Notice of Privacy Practices, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability Bill of Rights and Responsibilities.
- I authorize National Sleep Solutions to photograph me, include my photograph in my medical records, and videotape me during the sleep study for the purposes of diagnosing and treating my condition.
- I authorize National Sleep Solutions to use and disclose my medical information to other healthcare providers; to my insurance carrier to process my claims and payments; and to staff conducting healthcare operations.
- I authorize my insurer to pay National Sleep Solutions directly for benefits, if any, otherwise payable to me.
- I acknowledge that National Sleep Solutions does not accept workers' compensation insurance or personal injury cases. In these circumstances, payment for treatment will be required at the time of service.
- I understand that I am responsible for the deductible, co-payment, co-insurance and any other charges not covered by insurance. If I do not have insurance, I acknowledge that I am obligated to pay the full amount.

_____ _____

Signature of Patient or Responsible Party Date

4 Bradley Park Ct Suite 3A, Columbus, GA 31904 Fax 706-955-1746

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

National Sleep Solutions is required by law to maintain the privacy and security of your protected health information, abide by the legal duties and privacy practices described in this Notice, and provide you with a copy of this Notice. This Notice became effective on August 1st, 2001, and remains in effect until replaced.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are several ways in which your physician, our office staff and others outside of our office involved in your care are permitted to use and disclose your protected health information without your written authorization. Protected health information ("medical information") is individually identifiable health information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services rendered. The following list describes different ways that we are permitted to use and disclose your protected health information, however this list is not meant to be exhaustive.

- **TREATMENT**. We may use and disclose your medical information without your prior approval to provide, coordinate, or manage your health care and related services. For example, we may request information from your primary care physician pertaining to your care or provide information to your primary care physician about your condition.

- **PAYMENT** . We are permitted to use and disclose your medical information to obtain payment from your insurer for items / services rendered to you. For example, prior to your sleep study, we may be required to disclose information about you to your health plan in order to obtain preauthorization for the procedure.

- **HEALTH CARE OPERATIONS**. We may use and disclose your medical information for health care operations. Our health care operations include: assessment of healthcare quality and improvement activities; reviewing and evaluating the competence, qualifications and performance of our health care professionals; health care training programs; accreditation, certification, licensing and credentialing activities; medical records review, audits, and legal services; business planning, development, management and administrative activities.

We are also permitted to use and disclose your medical information without your prior approval, when authorized and required by law, for the following kinds of public health and benefit activities: 1) for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence; 2) to avert a serious and imminent threat to public health or safety; 3) for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud and abuse agencies; 4) for research; 5) to entities subject to FDA regulation regarding FDA-regulated products or activities; 6) in response to court and administrative orders and other lawful process; 7) to law enforcement officials with regard to crime victims and criminal activities; 8) to comply with OSHA or similar state laws regarding work-related illness or injury; 9) to comply with workers' compensation laws and similar programs; 10) to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; 11) to coroners, medical examiners, funeral directors, and organ procurement organizations; and 12) disclosures otherwise specifically required by law.

We may disclose your medical information to a family member, friend or other person involved in your care or responsible for payment of your care but will disclose only information that is relevant to his / her involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to deter- mine whether disclosing your medical information is in your best interest under the circumstances.

In any other situation not described above, we will not use and disclose your medical information without your express written authorization. Uses and disclosures of your medical information for marketing and fundraising purposes and uses and disclosures that constitute sales of medical information about you will only be made with your signed permission. You have the right to opt out of receiving fundraising communications.

If you sign an authorization to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses al- ready made or taken in reliance on that authorization.

PATIENTS' RIGHTS

You have the following rights regarding the protected health information that we maintain about you:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with limited exceptions. We will provide your medical information to you in the format that you request unless we cannot practicably do so. Your request must be made in writing. Fees may apply for copying and mailing the information to you.

- You have the right to request that we amend your medical information if you believe that it is incorrect or in- complete. Your request must be made in writing. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.

- You have the right to request that we not use or share your medical information for purposes of treatment, payment, or our health care operations, or with family, friends or others whom you specify. Your request must state the specific restriction requested and to whom you want the restriction to apply. Also, if you pay for a service or item out-of-pocket, you can request that we not share your medical information with your insurer. All requests must be made in writing. We are not required to agree to your request if your request adversely affects your care and is not in your best interests.

- You have the right to request an accounting of all uses and disclosures of your medical information to others for purposes other than treatment, payment or health care operations that we have made during the six years prior to the date of your request. Your request must be made in writing.

- In the event of a breach that may have compromised the privacy or security of your medical information, you have the right to receive notice of such breach.

- You have the right to request that we contact you with confidential communications in a specific way, such as by home or office phone, or by mail to a different address. Your request must be made in writing.

- You have the right to obtain a paper copy of this Notice from us, upon request, even if you receive this Notice electronically or view this Notice on our website.

We reserve the right to change the terms of this Notice at any time and to make revisions applicable to all medical information that we maintain, including medical information that we may have created or received before we made the change. For further information about our privacy practices, or to submit requests, please contact our Office Manager or Compliance Officer.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our Office Manager, Compliance Officer, or with the Office for Civil Rights of the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to privacy of your medical information. We will not retaliate against you if you elect to file a complaint under any circumstances.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

_____ _____ /_____ /_____

Signature of Patient or Responsible Party Date

In accordance with the Health Insurance Portability and Accountability Act of 1996, National Sleep Solutions may not use or disclose your health information except as specified in its Notice of Privacy Practices without your express authorization. To authorize disclosure of your health information under the following circumstances, please complete and sign this form.

PATIENT INFORMATION		
Name:	Date Of Birth:	Age:
CLINCIAL INFORMATION __ I hereby authorize National Sleep Solutions to disclose my clinical information to family members. __ I hereby authorize National Sleep Solutions to disclose my clinical information only to the following persons:		
Name:	Relationship to Patient:	
Name:	Relationship to Patient:	
BILLING AND SCHEDULING INFORMATION __ I hereby authorize National Sleep Solutions to disclose billing and scheduling information to family members. __ I hereby authorize National Sleep Solutions to disclose billing and scheduling information only to the following persons:		
Name:	Relationship to Patient:	
Name:	Relationship to Patient:	
APPOINTMENT INFORMATION		
I hereby authorize National Sleep Solutions to leave appointment reminders for me in the following way(s): □ Telephone #:_____ _____ _____ □Voicemail □Text Message Home Work Cell □ Mailing Address: _____ □ Email Address:_____		
EMAIL AND TEXT COMMUNICATIONS		

Although reasonable means will be used to protect email communications and text messages sent to and/or received from patients, the privacy, security and confidentiality of these messages cannot be guaranteed. The risks of email and text messaging include, but are not limited to:

- Email communications and text messages can be circulated, forwarded, and broadcast to unintended recipients.
- Email communications and texts messages can be intercepted, altered, forwarded or used without authorization or detection; errors can occur in the transmission process.
- Email is indelible. Even after the sender and recipient have deleted copies of the email, back-up copies may exist on a computer or in cyberspace.
- Employers and online services may have the right to inspect and keep communications that pass through their system.

- Email communications are easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Email communications can introduce viruses into a computer system and potentially damage or disrupt a computer.
- Email communications and text messages can be used as evidence in court.

Terms and Conditions of Use of Email Communications and Text Messages

- Email/text communications to and from patients concerning diagnosis or treatment may be printed out and included in patients' medical records. Because email/text communications may be part of medical records, individuals authorized to access these records, such as clinical staff and billing personnel, will have access to the communications.
- Email/text communications may be forwarded internally to staff members and others involved in the patient's care, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other related matters. These communications will not be forwarded to independent third parties without the patient's written consent, except as authorized or required by law.
- Although every effort will be made to read and respond to email/text communications promptly, there is no guarantee that these communications will be read and responded to within any particular time frame. In an urgent or emergency situation, the patient should call healthcare provider or go to Emergency Room and not rely on e-mail or texts.
- If the patient's email/text communications require or invite a response and the patient has not received a response within a reasonable period of time, it is the patient's responsibility to determine whether the intended recipient received the communication and when the recipient will respond.
- Email/text communications should not be used to communicate sensitive medical information such as that relating to HIV, mental health or substance abuse.
- The patient is responsible for notifying the office staff of any type of information that the patient does not want to be sent by email or text messages.
- National Sleep Solutions is not responsible for loss of information due to technical failures associated with patient's email or text messaging software or internet service provider.
- In the event that the patient does not comply with the conditions herein, the patient's privilege to communicate by email or text messages may be terminated.

Guidelines for Communicating via Email or Text Messages

- Limit or avoid using an employer's computer or other third party's computer.
- Notify the office staff of any changes to the email address or cell phone number for text messages.
- Insert topic of email communication in the subject line and patient's name in the body of the email.
- Take precautions to preserve privacy and confidentiality by using, for example, screen savers and by protecting computer passwords.
- Exercise caution when using mobile devices in public places where others may eavesdrop on these communications.

□ I hereby consent to have National Sleep Solutions staff communicate with me via e-mail or text messages. I understand and acknowledge that National Sleep Solutions cannot guarantee privacy, security or confidentiality of information transmitted via email or text messaging.

I certify that I have read and understand this form and I voluntarily agree to the uses and disclosures of information as described. Furthermore, I understand that I may revoke this authorization at any time by submitting written notice to National Sleep Solutions.

_____ _____

Signature of Patient or Responsible Party Date

If Responsible Party, Relationship to Patient _____

WELCOME TO OUR PRACTICE

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. National Sleep Solutions is dedicated to providing you with the highest quality of care in sleep medicine. We are committed to working closely with you and your physician to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our administrative and financial policies.

OFFICE HOURS

Our normal business hours are Monday through Friday 8:00 AM to 5:00PM EST) We are closed for lunch from 12PM to 1PM. For assistance after normal hours with the home sleep apnea test, please call 888-884-9493 ext. 711. For all other matters, please leave a message on the voicemail and we will return your phone call within 24 hours.

SCHEDULING APPOINTMENTS

Office visits for initial examinations, consultations, PAP device delivery and setup, and follow-up appointments are scheduled during normal business hours; in-laboratory sleep studies are scheduled each night of the week with limited exceptions. Generally test results are available within one week of the sleep study. To schedule an appointment, please call our office during normal business hours.

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, please notify our office during business hours at least 24 hours prior to your appointment. By doing so, you will not incur a cancellation fee. However, if you do not cancel and do not show up for your appointment, a fee of $35 for daytime appointments and a fee of $150 for overnight sleep study appointments may be billed to you for which you may be responsible. Please bear in mind that for each overnight study a private room is reserved for you and a sleep technologist is assigned to you, so costs are incurred when planning and preparing for your sleep study. Kindly call our office as far in advance as possible should you need to reschedule your appointment.

CONFIDENTIALITY OF MEDICAL RECORDS

National Sleep Solutions is committed to protecting the confidentiality of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the circumstances in which we are permitted to use and disclose your protected health information, and your rights to access and control your health information. All records that we create or receive concerning your health or condition and the services rendered are confidential and cannot be disclosed without prior written authorization, except as otherwise permitted by law.

RECORDS REQUESTS

To authorize release of your medical information to a specific person or entity, or to request a personal copy of your own medical records, we require that you submit your request in writing to the Office Manager. (Standard authorization forms can be obtained from the receptionist.) By law, we are required to retain your medical records for 7 years. If you are requesting that our staff complete forms on your behalf, such as short-term disability forms or creditor forms, please allow our staff 48 hours to respond to your request. We charge $35 per form.

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. National Sleep Solutions accepts most major insurance carriers. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are covered benefits in all insurance policies. In some cases, you may be responsible for amounts not covered by insurance such as the deductible, copayment, coinsurance, and any unpaid balance. We will make every effort to determine, and disclose to you, whether our services are covered by your health insurance plan before the service is provided. If you have any questions or are uncertain as to your health plan's coverage, please do not hesitate to contact us for assistance.

Payment Options

- **Insured Patients:** We require that you present a current copy of your insurance card to the receptionist at the time of service. Although we may estimate the amount that your insurance carrier will pay for services rendered, it is your insurer that ultimately makes the final determination of your benefits eligibility and payment. Once your claim is processed by your insurance company, any amounts not covered by insurance will be billed to you and it is your obligation to pay these charges. At the time of service, you must pay any applicable deductible, copayment, and/or coinsurance.

- **Private Pay / Uninsured Patients:** You are expected to pay the full amount for services rendered at the time of service if 1) you do not have insurance coverage; 2) your insurance carrier declines to cover a specific service; 3) National Sleep Solutions is not contracted with your insurer; or 4) you are paid directly by your insurance company. In some instances, payment arrangements may be made prior to the date of service. If prearranged payments are approved, we will require a valid credit card on file.

Refunds: If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

Returned Checks: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment. Future visits will need to be paid in cash.

Account Balances: If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

Workers' Compensation / Personal Injury: We do not accept workers' compensation or personal injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time of service.

Disputes: Any disputes of your account should be submitted in writing within 30 days of receipt of the

monthly statement. You will be notified of the outcome within 14 days of receipt of your dispute.

COMPLAINTS AND CONCERNS

To file a complaint or grievance, please complete our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your issues.