Name: ______________________ DOB: __________ Appointment Date: _____________ Time:__________

Sandman Sleep Lab

Sleep Study

Information Package

Sandman Sleep Lab is located at
2030 Truxtun Avenue
Parking is in the back of the building.

Northeast Corner of Truxtun and "D" Street
(Across Truxtun Ave from Mercy Hospital Downtown)

Look for the "Sleep Lab Entrance" sign on the back of the building.
Enter the gate on the left side of the back of the building.
Use the first door you come to after entering the gate.
It is OK to knock on the door.
One or more of our technologists will be there waiting for *you.*

The EMERGENCY number for the night of your study is

661-395-0471

Please complete all forms and questionnaires
Pages 2 thru 6.
And
Please review and follow all instructions
Pages 7 thru 9

Bring this booklet with you on the night of the study.

Please Arrive at Sandman ON TIME!
Welcome to Sandman

Patient Registration

Patient Name: ____ Date of Birth: _____________
Gender: Male: ____ Female: ______
Marital Status
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Address: ____
City: ____ State: _______ Zip: ______
SS#________________________ Driver's License: __________________ State:_____________
Phone#: ____________________________ Cell phone#: _______________________________

Referring doctor: _____________________ Referring doctors phone #: ___________________
Insurance: ___________________________ ID#: ______________________ GRP#: ____________
Subscriber: ____________________________ Subscribers DOB: _________________________
Employer: ____________________________ Employers Phone number: ___________________

Responsible Party if other than Patient
Name: ___________________________________ DOB: _________ SS#: ___________________
Address: ___________________________ City: ______________ State: ______ Zip: __________
Employer: _______________________________ Employers Phone number: ________________

Emergency Contacts:
Emergency Spouse Contact: ____
Phone Number: ________________________

Emergency Contact other than spouse: ____
Relationship: ___________________________
Emergency Contact Address: ____
Phone Number: ________________________

Sandman Technologies, Inc.
2030 Truxtun Ave. Bakersfield, CA 93301
(661) 395-0471
661-332-9564

Assignment of Insurance Benefits

I hereby authorize direct payment of medical benefits to Sandman Technologies, Inc. for services rendered. I understand that I am financially liable for any balance of charges not covered by my insurance, including cancellation fees or insurance payments made directly to me.

Authorization to Release Information

I hereby authorize Sandman Technologies, Inc. to release any medical or incident information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare Authorization

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment authorized benefits be made on my behalf.

Patient Privacy

I certify that I have reviewed the enclosed patient privacy (HIPAA) documentation. A photocopy of these assignments shall be valid as the original.

Patient's Signature: ____________________________________Date:___________________________
If under 18 years of age:
Parent / Guardian (Please Print): ____

Parent / Guardian Signature:____Date:___________________________

NO SHOW - CANCELLATION POLICY

Why is there a cancellation fee?

As you may remember, the schedule for our sleep studies is booked up for several weeks in advance. Scheduling is a complex process. We must insure that your technologist and bedroom are available for the study and that the equipment is in good working order. A great deal of preparation is performed in the 48 hours prior to your arrival at Sandman. When we receive last minute cancellations, it is usually too late to book a new patient. Because of this, it is imperative that you let us know if you are unable to keep your appointment well in advance.

There is a 150.00 charge
for appointments that are not kept or are cancelled
with less than 48 hours (2 business days) notice.
You will be responsible for these charges. Your health insurance WILL NOT PAY this fee.

We apologize for this strict policy, but is the only way we can guarantee that you will receive the best possible care at Sandman. Thank you for your cooperation.

NAME: ________________________________ DOB: ________DATE:____________

Sex: ________ Ht:__________ Wt:________ Age:______ BMI:__________

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, 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 work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation.

O = 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	_________
As a car passenger for an hour without a break	_________
Lying down to rest in the afternoon ……...............................	_________
Sitting and talking to someone …...	_________
Sitting quietly after lunch without alcohol	_________
In a car, while stopping for a few minutes in traffic	_________

TOTAL > ___________

A score of greater than 10 is a definite cause for concern as it indicates significant excessive daytime sleepiness.

HAVE YOU BEEN CLINICALLY DIAGNOSED WITH ANY OF THE FOLLOWING:
(check all that apply)

Rapid Heart Rate: Murmur: Arrhythmia: Leaky Valve: COPD:
High blood pressure: Stroke: Heart attack: Congestive heart Failure:
Pacemaker: GERD (Acid Reflux): Depression / Bipolar Disorder / Schizophrenia:
Diabetes (If yes, treated with (check one) Insulin: Pills: Diet:
Insomnia How often? ___________ Rx to sleep: ___________________

As an adult, have you had surgery to correct your nose or throat?
____

Other: ____

SLEEP QUESTIONNAIRE

	YES	NO
1. Do you drink alcoholic beverages? If yes:		
*5 or more drinks per day		
*3-4 drinks per day		
*1-2 drinks per day		
*8 or more drinks per week		
*4-7 drinks per week		
*1-3 drinks per week		
*Less than 1 drink per week		
*Drinks no alcoholic beverages		
2. Do you consider yourself to be a Day Person?	Night Person?	
3. What hours do you work?		
4. What time do you normally go to bed?		
5. What time do you normally awaken for the beginning of your day?		
6. How long does it usually take you to fall asleep?		
7. How many hours of sleep do require in order to feel rested?		
8. How many hours of sleep do you normally sleep?		
9. How many hours of extra sleep do you get on your days off?		

	Never	Rarely	Often	Always
10. How often do you have trouble falling asleep?				
When this happens, do you…………				
*Experience your mind racing				
*Feel worried or depressed				
*Feel physical pain or discomfort?				
*Feel it difficult to keep your arms or legs still?				
*Use over the counter medications to fall asleep?				
*Use prescription medication to fall asleep?				
*Use alcohol to fall asleep?				
*Use illicit drugs to fall asleep?				

	Never	Rarely	Often	Always
11. How often do you:				
*Grind your teeth during the night?				
*Walk or talk in your sleep?				
*Have restless sleep … unable to keep still				
*Tear up the covers of your bed during sleep?				
*Make sudden jerks or movements during sleep?				
*Have frightening nightmares?				
*Have vivid dreams soon after falling asleep?				
*Remember your dreams				
*Have seizures or convulsions during sleep?				
*Experience bed wetting?				
*Have nasal congestion during the night?				
*Experience excessive sweating while sleeping?				

	Never	Rarely	Often	Always
12. Have you ever been told that you snore? When you snore, do you:				
*Snore loudly?				
*Snore loudly only on your back?				
*Snore loudly in all sleep positions?				
*Do you, or have you been told, that you snort or gasp for breath?				
*Do you, or have you been told , that you struggle for breath?				
*Do you awaken during the night to use the restroom?				

	Never	Rarely	Often	Always
13. How often do you wake up…..				
*Because of physical pain?				
*Because of heartburn?				
*Because of unknown reasons?				
14. Do you ever awaken choking or gasping for breath?				
15. Have you ever been told that you stop breathing during sleep?				
16. Do you ever awaken with chest pain or heart palpitations?				
17. Do you ever awaken during the night with headaches?				
	Never	Rarely	Often	Always

18. Do you ever awaken unable to move, yet mentally alert?				
19. In the morning, do you awaken………				
*Still feeling tired?				
*Feeling confused or irritable?				
*With any physical pain?				
*Long before the alarm, unable to return to sleep?				
*Do you need an alarm to wake up?				
*With headaches?				
20. Do you use caffeinated beverages or medications to stay awake?				
21. Do you ever feel weak when you laugh, cry or become excited?				
22. Do you feel that your memory is getting worse?				
23. Do you find it harder to concentrate?				
24. Do you think you are experiencing changes in your personality?				
If you take more than ten medications, please bring your complete list with you.				

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Instructions for In-Lab Sleep Study Procedures

On the day of your Study:

- ❖ Do not eat or drink caffeine after 12:00 noon. The following foods and drinks contain high levels of caffeine.
  - Coffee
  - Chocolate
  - Most tea, including iced tea, traditional black tea and green tea

* Please do not consume any alcoholic beverages or intoxication substances on the day of your study. Patients under the effect of alcohol or non prescription drugs will not be able to perform their study. Patients who drink daily should drink their normal amount and arrange a ride to the facility. Anyone who doesn't drink daily should avoid alcohol

- **<u>No</u> Hair extensions or Weaves**
- **<u>No</u> Naps all day**

* Before coming to the sleep center
  - _ Eat a normal meal.
  - _ Bathe, wash and dry your hair, and do not apply hair sprays, oils, gels, colognes or perfumes.
  - _ Complete all forms and paperwork.
  - _ Men: You do not need to shave off your mustache or beard but please "clean up" the area.

Please Bring:

1. Your bedtime clothes and change of clothes for the next day.
2. A book or magazine for reading. There is a TV with cable in your room.
3. Your toiletries (i.e. toothpaste, toothbrush, etc.)
4. Your medications as prescribed and ordered by your doctor. Sandman does not and cannot provide you with medications. There are instances where certain medications are not to be taken but should only be discontinued with the consent of your physician.
5. Your co-payment if applicable.
6. Your completed and signed Sleep Study Information Packet (questionnaires.)

No Personal Pillows or Blankets

The PSG (Polysomnogram) Procedure:

PSG's are the most common procedure performed at Sandman. During a PSG we are able to monitor your sleep patterns and signs of sleep disorders such as Obstructive Sleep Apnea and Periodic Limb Movements.

When you arrive at the center, the technologist will ask you to change into your night clothes and fill out a bedtime questionnaire. He/she will then mark and measure your head to apply the proper placements of the EEG (brain wave) electrodes. Don't worry, none of the monitoring

devices will be painful. The entire hook-up procedure takes approximately 20 minutes.

We will be monitoring the following parameters:

EEG - (Electroencephalograph or brain waves) Electrodes to monitor your stages of sleep.
EOG - (Electro-oculograph - eye movements) Electrodes to monitor your eye movements.
EMG - (Electro-myograph - muscle activity) Electrodes to monitor limb movement and chin activity
ECG - (Electro-cardiograph or heart rate) to monitor your heart beat and rhythm.
Respiration - Your nose and mouth will be monitored by a thermocouple, which looks like a small oxygen cannula. Your chest and abdominal respiratory efforts will be monitored by adhesive sensors which are placed around or on your abdomen and chest.
Oximetry - A finger probe that will read your oxygen saturation levels throughout the night.

During the Night:

We typically start the sleep study between 9:00 - 11:00pm. You will go to sleep as you normally would at home. You are allowed to sleep in any position during the night. The monitoring devices are all connected to a small “jack box” which is easily disconnected and carried with you as you move about the center. The monitoring devices are very sturdy. If a monitoring device gets pulled off, the technician will fix it.

Even if you are only scheduled for a standard PSG, it may be necessary for us to apply CPAP at some point during the night. In many cases, Standard PSG’s are followed up with a CPAP Titration several days after your study. The paragraphs on the following page describe the process of CPAP titration. You may find it helpful to briefly review that material also.

In the Morning:

After your study the technician will remove all of the monitoring devices. This process takes about 5 minutes. Afterwards, you are free to wash up at the center. The study will end between 5:00 - 6:00am. A continental breakfast (muffins, juices and coffee) will also be available.

Instructions for CPAP Titration and Split-Night Studies

During your sleep study, we will be monitoring your response to Continuous Positive Airway Pressure commonly called CPAP. This device gently blows filtered room air into your nose through a small mask. CPAP helps keep the airway open so that you can breathe normally throughout the night. Every one requires a different CPAP pressure and your technologist will be adjusting this via remote control throughout the night. During a CPAP titration you are also allowed to sleep in any position, however we would still like to see some time on your back. If you are already on CPAP, please bring your mask with you to your study - your technologist

will check it for fit and wear.

Sandman Sleep Lab
2030 Truxtun Ave. Bakersfield CA 93301
661-395-0471

Notice of Privacy Practices Acknowledgement Form

I understand Sandman Sleep Lab has to right to use your protected health information in the normal course of providing services and obtaining reimbursment for such services. Sandman's HIPPA privacy Practice Describes how Medical information about you may be used and disclosed and how you can get access to this information, please review it carefully as it explains:

1. How sandman will use and disclose your protected Health information.
2. Your privacy rights with regard to your protected Health Information.
3. Sandman obligations concerning the use and disclosure of your Protected Health Information.

I acknowledge that I have received a copy of Sandman's HIPPA policy practices. I further acknowledge and agree to Sandman's policies.

Patient Name (Print): ____

Patient Signature: ____ **Date:** __________

Saandman Sleep Lab

FINANCIAL AUTHORIZATION & RELEASE FORM

I hereby acknowledge that I am receiving or am scheduled to receive health care services, including, but not limited APAP and HST related services. I understand that payments for the services rendered on my behalf are my sole responsibility. I hereby authorize Sandman Sleep Lab to:

1. Bill my insurance provider and receive payment directly for all services rendered on my behalf. Should my insurance send payment for these services to me, I will pay the entire payment received by me to Company.   Service will include Sleep Studies and any post treatment authorized by me.

2. Bill me for any amounts not paid by my insurance provider. These include, but not limited to, co-payments, deductibles, and non-covered services. I understand that these are determined by my insurance provider and policy and authorize Company to charge my credit card for such amounts. I agree to be responsible for all resulting balances and release Company from any liability relating to any such balances.

Accepting Assignment

I understand that Company will accept assignment for all covered services provided. Assignment is defined as "Reasonable and Customary Charge" for covered services. These are established by the insurance provider for the geographical area in which the service is provided.

Liability Release

I authorize access to all of my insurance information and medical records necessary for billing the related health care services. I hereby give permission to release any medical information or insurance information in order to file any insurance claims. I release Company from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on me or my dependent to be paid directly to the provider and payment for services in my or my dependents' behalf are my sole responsibility. I understand that a separate bill for interpretation may be sent from the interpreting physician.

I certify that I have read and understand the above information, my responsibilities and I have access to a copy of this form.

Print Patient Name: ____

Signature of Patient or Responsible Representative: ____________________________

Date: ____ Time: _________________________

If a representative is signing for the patient, List relationship and Print Name below

Relationship:__________________________________ Print Name: _________________________

Sandman Sleep Lab

2030 Truxtun Ave. Bakersfield CA 93301

661-395-0471

Acknowledgement and Consent for Sleep Study

Your Physician has referred you for a sleep study because you meet the criteria for suspected sleep apnea.

I acknowledge I have received and understand the information below.

Please initial.

_____ 1. The technician has fully explained the procedure on performing the Sleep Study and any follow up required such as a repeat study.

_____ 2. An estimate of my cost for the testing to be performed based on the information provided by my insurance. I understand this is just an estimate and not a guarantee and my liability will be based on actual processing of my claim by my insurance.

_____ 3. I have received a copy of Sandman Sleep Lab's Patient rights Policy.

_____ 4. I have received a copy of Sandman Sleep Labs HIPPA Policy.

_____ 5. Payment Agreement

____

I consent for Sandman Sleep Lab to perform the describer Sleep Study and to follow the instructions given by me by the technician.

I am aware that due to the nature of sleep testing, I may have to repeat the study.

I am also aware that if I terminate the study early or refuse testing I will be billed the cancellation fee of $150.00

Date of the Study:_____________

Patient Name: ____________________________________ (Please Print)

Patient Signature : ________________________________ Date: ____________

Technicians Signature: ______________________________ Date: _____________

Sandman Sleep Lab

Patient Rights and Responsibilities

POLICY:

- Patient Rights

  Sandman Technologies, Inc. has adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:

  - Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.

  - Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.

  - Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.

  - Have his or her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues will be included during the initial nursing admission assessment.

  - Access protective and advocacy services or have these services accessed on the patient's behalf.

  - Appropriate assessment and management of pain.

  - Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

  - Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.

  - Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.

  - Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.

  - Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.

- Formulate advance directives regarding his or her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by state laws and regulations).

- Have a family member or representative of his or her choice notified promptly of his or her admission to the facility.

- Have his or her personal physician notified promptly of his or her admission to the facility.

- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.

- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.

- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.

- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).

- Reasonable responses to any reasonable request he/she may make for service.

- Leave the facility even against the advice of his/her physician.

- Reasonable continuity of care.

- Be advised of the facility grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.

- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient’s right to access care, treatment or services.

- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient’s right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).

- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.

- Examine and receive an explanation of his/her bill regardless of source of payment.

- Know which facility rules and policies apply to his/her conduct while a patient.

- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.

A patient has a right to issue a valid complaint to management and its accrediting body.

Reporting process

1. Contact Sandman Sleep Lab by phone or in writing
   a. Sandman Sleep Attention Albert Bensuen
      2030 Truxtun Ave Bakersfield, Ca 93301
      661-395-0471
2. Contact ACHC
   a. 139 Weston Oaks Ct, Cary NC 27513
      1-855-937-2242

All facility personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

- Patient Responsibilities:

  - The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

    - The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.

    - The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.

    - The patient and family are responsible for asking questions about the patient's condition, treatments, procedures, Clinical Laboratory and other diagnostic test results.

    - The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

    - The patient and family are responsible for immediately reporting any concerns or errors they may observe.

    - The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.

    - The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.

- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.

- The patient is responsible for assuring that the financial obligations of his/her facility care are fulfilled as promptly as possible.

- The patient is responsible for following facility policies and procedures.

- The patient is responsible for being considerate of the rights of other patients and facility personnel.

- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

- Lab Responsibilities:

    - The Supervisor and Sleep Technologist are responsible to ensure that this policy/procedure is followed. Any HIPAA related issues/questions that a patient might have should be directed to the Lab Supervisor.

    - Sandman Technologies will provide information on the rights and responsibilities of patients who are referred for polysomnography. The patient will also be given access to the current HIPAA policy regarding the handling of their medical records.

- Procedure

    - Each patient who has an HST Home sleep study at Sandman Technologies has the right to make informed decisions regarding their care.

    - The patient will be informed about hookup procedures and mechanisms used in the HST

    - The Sleep Center will ensure the continuity of care for all patients receiving a sleep study.

    - All patients will receive services in a timely manner that is consistent with their needs and with Sandman Technologies, Inc. policies and procedures.

    - Sandman Technologies, Inc. staff will honor all patients' rights as stated above and will inform patients of their responsibilities during the sleep recording.

Sandman Sleep Lab

2030 Truxtun Ave Bakersfield, CA 93301
661-395-0471

HIPPA Policy

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.**

You're Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
  Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.