Patient Information Sheet

Date: _______/______/____________ Referring Doctor/Other: ________________________________

Patient Name: (Last) ___________________________ (First) ______________________ (Middle Initial) ______

Address: (Street) __________________________ (City) _____________ (State) ____________ (Zip) _________

Main Ph. Number: (_______) _________-____________ Other Ph. Number: (_______) ___________-__________

Social Security # _________-_________-_______________ Date of Birth: _______/______/____________

eMail Address: ____@______________________________.com

Place of Employment: __________________________________ Occupation: ____________________________

Work Ph. Number (_____) ____________-_______________ Ext. ______________

RESPONSIBLE PARTY IF OTHER THAN SELF

Name: (Last) ___________________________ (First) ______________________ (Middle) ______________

Address: (Street) ___________________________ (City) ___________________ (State) ________ (Zip) _____

Home Ph. Number: (_______) _________-____________ Date of Birth: _______/______/____________

Relation to Patient: _________________________ Social Security # _________-_________-_______________

Place of Employment: __________________________________ Occupation: _______________________

Work Ph. Number: (_______) _________-____________ Ext._________________________

PLEASE GIVE ALL INSURANCE CARDS

AND A PHOTO ID TO THE RECEPTIONIST

NOTE: IF THE PRIMARY NAME ON THE POLICY IS OTHER THAN THE PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION.

Primary

Subscriber/ Owner ____________________________________ Relation to patient ________________________

Social Security # _________-_________-_______________ Date of Birth: _______/______/____________

Address: (Street) __________________________ (City) _____________ (State) ____________ (Zip) _________

Secondary

Subscriber/ Owner ____________________________________ Relation to patient ________________________

Social Security # _________-_________-_______________ Date of Birth: _______/______/____________

Address: (Street) __________________________ (City) _____________ (State) ____________ (Zip) _________

In the section below, please circle your responses.

Preferred Method of Communication Mail Phone eMail

Gender Male Female **Marital Status** Married Single Divorced Widowed Separated

Race White Black/African American Asian American Indian/Alaska Native Native Hawaiian/Pacific Isl

Hispanic/Latino Not Hispanic/Latino Other ______________________

Preferred Language English Spanish Other ________________

Are you allergic to any medications? Yes No
If yes, please list:

____

Previous Surgeries, Heart Attacks, Strokes, Hospitalizations (Please list and date):

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

Current Medications and Dosage (Prescription and over-the-counter):

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

Tobacco Use:
- □ Current Every Day
- □ Current Some Day
- □ Former
- □ Never

Alcohol Use:
- □ Current Every Day
- □ Current Some Day
- □ Former
- □ Never

What form of tobacco? Smoke Dip Chew

Preferred Pharmacy Information

Pharmacy Name ____________________________________ Pharmacy Phone (______) ______________

Pharmacy Address ____________________________ City ______________ State ________ Zip ________

Epworth Sleepiness Scale

Name: ________________________ Date: ______________

Your age: _______ Sex (circle one): Male Female

How likely are you to doze off or fall asleep in the situations described below in contrast to feeling just tired? Even if you haven't 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.

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing Circle the Number that Applies
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g. a theatre or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch (without alcohol)	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

Add circled numbers together to get total Epworth Sleepiness Score -- __________

www.somnussleepclinic.com

Financial Responsibility

I authorize payment of medical benefits to Somnus Sleep Clinic and/or Sleep Associates. If by mistake, my insurance company remits payment to me, I agree to send payment, along with any enclosed paperwork, to Somnus Sleep Clinic and/or Sleep Associates to be applied to my account.

I understand that my insurance company expects me to pay to my provider my copays or co-insurance at the time of service. I understand that Somnus Sleep Clinic and/or Sleep Associates are filing the remainder of my bill with my insurance company as a courtesy and that I am responsible for any unpaid balances in full.

Patient/Guardian Signature ______________________________ Date ________________

Cancellation / No-Show Policy

We understand there may be times when you miss an appointment due to emergencies or other obligations. We request that you give us a courtesy call 24 hours in advance of your study or appointment. Patients who fail to keep their scheduled doctor's appointment without giving 24 hour notice will be charged a $25 fee. Patients who fail to keep their scheduled Sleep Study or do not show without giving 24 hour notice will be charged a $150 fee.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ________________________________, have received a copy of Somnus Sleep
Patient's Name or Guardian's Name

Clinic's Notice of Privacy Practices.

____________________________________ ______________
Signature of Patient or Personal Representative Date

OFFICIAL USE ONLY

I ATTEMPTED TO OBTAIN PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES. I WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: __________ Initials: ________ Reason: ____

Authorized Release of Personal Medical Information

Please list family member/others who may need to speak with any of our staff regarding, but not limited to, your medical information such as:

- Coordination of Care
- Billing / Insurance
- Scheduling

Name____ Date of Birth: ______/_____/__________

Relationship_____________________________ Phone Number (______) _________-__________

Specific Instructions or Limitations____

Name____ Date of Birth: ______/_____/__________

Relationship_____________________________ Phone Number (______) _________-__________

Specific Instructions or Limitations____

Name____ Date of Birth: ______/_____/__________

Relationship_____________________________ Phone Number (______) _________-__________

Specific Instructions or Limitations____

This authorization will remain in effect unless request is received by our office in writing.

By signing this form, I authorize the release of my personal medical information to above persons.

____ ____________________________

Patient / Authorized Signature Date

SOMNUS SLEEP CLINIC OF CENTRAL MISSISSIPPI, LLC

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the waiting room. You can also request a copy of this notice from the contact person listed in Section VI below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example we may disclose your demographic information to anesthesia care providers for payment of their services.

3. **For health care operations.** We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Authorization.

Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures.

Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than

is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to November 1, 2005.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Catherine Hayes, Office Manager, Somnus Sleep Clinic of Central MS, LLC, 1006 Treetops Blvd., Suite 102, Flowood, MS 39232-7645. Phone 601-939-1808.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice is effective September 25, 2012