SLEEP HEALTH MD

SANTA CRUZ • WATSONVILLE • MONTEREY • SUNNYVALE
TELEPHONE: (844) 38SLEEP • FAX: (866) 264-3890
Website: www.sleephealthmd.com
Patient Portal: https://2256.portal.athenahealth.com/

PATIENT MUST BE PRESENT AT EVERY VISIT !

PATIENTS INFORMATION:

LAST NAME _____ FIRST _____ M.I. _____ TODAY'S DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME NUMBER _____ CHILD'S GENDER _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____-_____-_____ INSURANCE NAME _____ ID NUMBER _____ GROUP NUMBER _____

PARENTS INFORMATION:

(MOTHER'S NAME) _____ HOME NUMBER _____ CELL PHONE _____ SOCIAL SECURITY # _____-_____-_____

(FATHER'S NAME) _____ HOME NUMBER _____ CELL PHONE _____ SOCIAL SECURITY # _____-_____-_____

REFERRING M.D. _____ PRIMARY CARE M.D (IF DIFFERENT) _____

ASSIGNMENT AND RELEASE: I, the undersigned, have insurance coverage with_____, andassign directly to Sleep Health MD all medical benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether paid or not by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

INSURED SIGNATURE / GUARDIAN _____ DATE _____

PEDIATRIC QUESTIONNAIRE

NAME_____ **TODAY'S DATE:** _____

DATE OF BIRTH:_____/_____/____ **AGE:**_____ **HEIGHT:**_____ **WEIGHT**: ____

PRIMARY CARE PHYSICIAN:_____

PHYSICIAN WHO REFERRED YOU TO SLEEP HEALTH MD: _____

OTHER PHYSICIANS YOU SEE:

1. _____
2. _____
3. _____

MEDICATION ALLERGIES: _____

_____

_____

1. What problems does your child have that led to this sleep evaluation?

_____

_____

_____

2. On school nights
   What time does the child go to bed?
   How long to fall asleep?
   What time does child wake up?

_____

_____

_____

3. On weekends/vacation
   What time does the child go to bed?
   How long to fall asleep?
   What time does child wake up?

_____

_____

_____

4. Does the child have their own bedroom?
   YES NO

Their own bed YES NO

PHYSICIAN'S NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5. Is a parent present when the child falls asleep?

6. Does your child snore? YES NO

Describe your snoring:

_____ Light
_____ Occasional
_____ Constant
_____ Heavy
_____ Other

7. Do you ever observe your child stop breathing, gasp or choke during sleep?

YES NO

8. How many times does your child awaken after falling asleep? _____

Reasons:

_____Need to urinate
_____Shortness of breath
_____Screaming
_____Anxiety
_____Nightmares
_____Pain
_____Restless or painful legs
_____Heartburn
_____Nasal congestion
_____Headaches
_____Dry mouth
_____ Nasal congestion

9. Does your child have any of the following:

_____ Sweating while sleeping
_____ Teeth grinding
_____ Sleep walking
_____ Sleep talking
_____ Restless sleep
_____ Trouble getting up in the morning
_____ Mouth Breathing
_____ Sees frightening images before falling asleep or after awakening
_____ Does your child complain about not being able to move after they wake up
_____ Feels weak or loses control of muscles with strong emotion (such as laughter)

10. Does your child experience: check all that apply:

_____ Daytime sleepiness or fatigue
_____ Falling asleep in school
_____ Falling asleep with reading or tv
_____ Difficulty paying attention at home or school
_____ Depression
_____ Hyperactivity at home/school
_____ Aggressive behavior

11. How is your child's school performance?

_____ Above average
_____ Average
_____ Below Average

12. Does your child nap? YES NO

Number of naps per day _____or Per week _____

MEDICAL HISTORY:

13. Check all that apply:

_____Frequent nasal congestion or trouble breathing through the nose
_____ Sinus problems
_____ Chronic bronchitis or cough
_____ Allergies
_____ Frequent colds, flu, or sore throats
_____ Poor or delayed growth
_____ Excessive weight
_____ Hearing problems
_____ Speech problems
_____ Vision problems
_____ Headaches
_____ Pain
_____ Seizures or epilepsy

Any other medical problems? Please list:

_____
_____
_____

SOCIAL HISTORY

14. Are there pets in the home?

_____
_____

15. Are there smokers in the home?

_____
_____

16. Does your child drink caffeinated beverages (Coke, Pepsi, Mountain Dew, etc.)?

YES NO

If the answer is yes, how much per day

____

Does your child drink alcohol? YES NO

____

Does your child smoke cigarettes? YES NO

____

Is there any known drug use? YES NO

____

Does your child exercise? YES NO

____

17. Please list any previous hospitalizations or surgeries (including tonsils and adenoids)

____
____
____

Please list all medications:

____
____
____
____
____
____
____
____
____
____

____
Signature of Patient or Responsible Party Date

____
Printed name of Patient or Responsible Party Date

____
Physician Signature Date

Sleep Health MD Notice of Privacy Practices

Effective date, January 1, 2018

This notice describes how your medical information may be used and disclosed (provided to others) and how you can get access to this information. Please review this notice carefully.

This Notice of Privacy Practices explains how Sleep Health MD, its staff members and employees may use and provide your Protected Health Information (called PHI) to others for treatment, payment, and clinical "operations" as described below, and for other purposes allowed or required by law.

I. OUR PLEDGE:

Sleep Health MD takes the privacy of your health information seriously. We create a record of the care and services you receive to provide quality care to comply with legal requirements. We are required by law to keep your health information private and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep.

II. WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?

Protected Health Information (PHI) is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

III. WHAT DOES "CLINICAL OPERATIONS" INCLUDE?

"Clinical operations" includes activities such as discussions between staff and other health care providers; evaluating and improving quality; reviewing the skills, competence, and performance of staff; training future staff; dealing with insurance companies; carrying out company/employee reviews and auditing; collecting and studying information that could be used in legal cases; and managing business functions.

IV. HOW IS MEDICAL INFORMATION USED?

Sleep Health MD uses medical records to record health information, to plan care and treatment.

V. EXAMPLES OF HOW MEDICAL INFORMATION MAY BE USED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS:

Medical information may be used to show that a patient needs certain care, treatment, and services (such as lab tests, prescriptions, and treatment plans).

We will use medical information to plan treatment.

We may disclose Protected Health Information to another provider for treatment (such as referring doctors, and specialists).

We may fill out your requested claims for your insurance company containing medical information.

We may use the emergency contact information you gave us to contact you if the address we have on record is no longer correct.

We may contact you to remind you of your appointment by calling or emailing you.

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information about you, without prior authorization for public health purposes, health oversight audits or inspections and emergencies.

We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders or other legal process.

We may use or disclose health information about you for research purposes, subject to a special approval process.

VI. WHY DO I HAVE TO SIGN A CONSENT FORM?

When you sign the Consent for Release of Information, you are giving Sleep Health MD permission to use and disclose (provide to others) Protected Health Information for treatment, payment, and clinical operations, as described above. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment, or health care operations or as required or permitted by law.

VII. CAN I CHANGE MY MIND AND WITHDRAW PERMISSION FOR SLEEP HEALTH MD TO DISCLOSE PHI?

You may change your mind and withdraw (revoke) permission, but we cannot take back information that has been released up to that point. All requests to withdraw permission for uses and disclosures of PHI should be made in writing.

VIII. YOUR PRIVACY RIGHTS

The following explains your rights with respect to your Protected Health Information (called PHI) and a short description of how you may use these rights.

1. You have the right to review and to ask for a copy of your health information. This means that except as explained below, you may review and get a copy of your PHI that is contained in a "designated record set" as long as we keep the PHI. A designated record set contains medical and billing records and any other records that Sleep Health MD uses to make decisions about your care. You may not read or be given a copy of information collected for use in a civil, criminal, or administrative action, or court case; and certain PHI that is protected by law. In some situations, you may have the right to have this decision reviewed. If needed and at your request, Sleep Health MD may provide an electronic copy of your record if Sleep Health MD is able to do so. A fee will be charged for requesting a copy of your records.

2. You have the right to request that access to your health information be limited. This means you may ask us to restrict or limit the medical information we use or disclose for treatment, payment, or clinical operations (described above). Sleep Health MD is not required to agree to a restriction that you ask for. We will tell you if we reject your request. If we do agree to the requested restriction, we will not violate that restriction unless it must be violated to provide emergency treatment.

3. You have the right to request to receive private communications in another way or at other locations.

We will agree to reasonable requests. To carry out the request, we may also ask you for another address or another way to contact you, for example, mailing to a post office box.

4. You have the right to request access and changes to your health information. In most cases, you have the right to look at or get a copy of medical information that we used to make decisions about your care when you submit a written request. You may ask for changes to be made (amended) in PHI about you in a designated record set for as long as we keep this information. We may deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. A request must be submitted in writing.

5. You have the right to receive a record of when your health information has been disclosed by Sleep Health MD.

You have the right to request a record (accounting) of when Sleep Health MD has disclosed your PHI except for uses and disclosures for treatment, payment, and clinical operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

Requests for records about Sleep Health MD's disclosures of your PHI may not be made for time periods of more than six (6) years or it could be an earlier time period depending upon what the law requires.

6. You have the right to receive a paper copy of this Notice of Privacy Practices.

CHANGES TO THIS NOTICE

We may change our policies at any time. Changes will apply to medical records we already hold, as well as new information after the change occurs. You can receive a copy of the current notice at any time.

GENETIC INFORMAITON DISCRIMINATION ACT (GINA)

SHMD prohibits the use of genetic information. The definition set forth in GINA, defining "genetic information,: with respect to any individual, as (1) the individual's genetic tests; (2) the genetic tests of the individual's family members; and (3) the manifestation of a disease or disorder in family members of the individual. "Genetic information," as defined under both the state and federal law, also includes any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by an individual or family member of the individual.

BUSINESS ASSOCIATES

The Privacy Rule requires that a covered entity obtain satisfactory assurances from its business associate that the business associate will appropriately safeguard the protected health information it receives or creates on behalf of SHMD. The satisfactory assurances must be in writing, whether in the form of a contract or other agreement between SHMD and the business associate.

WHAT IF I HAVE A QUESTION OR COMPLAINT?

If you believe your privacy rights have been violated, you may file a complaint by contacting the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint. The address for the U.S. Department of Health and Human Services is:

Office For Civil Rights
US Department of Health and Human Services
Atlanta Federal Center
Suite 3B70
61 Forsyth St., SW
Atlanta, GA 30303-8909
(404) 562-7886 (phone)
(404) 562-7881 (fax) www.hhs.gov/ocr/hipa

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations, Assignment of Benefits and Consent to Obtain Medication History

I understand that as part of my healthcare, this organization Aaron B. Morse, M.D./Sleep Health MD originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and anyplans for future care or treatment. I understand that this information serves as a:

- basis for planning my care and treatment
- means of communication among the many health professionals who contribute to my care
- source of information for applying my diagnosis and surgical information to my bill
- means by which a third-party payer can verify that services billed were actually provided
- tool for routine healthcare operations such as assessing quality and reviewing the competence ofhealthcare professionals

Notice of Information Practices

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail acopy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required toagree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. If you have any questions regarding billing, please contact our billing compliance officer. **Initial here** _____

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s)directly to Dr. Aaron B. Morse for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for any amount not covered by insurance **Initial here** _____

Consent to Obtain Medication History

I authorize **Sleep Health MD** to view and download my medication history from SureScripts. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacybenefit managers may be viewable by my providers and staff here and it may include prescriptions back in time for several years. **Initial here** _____

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THATI AUTHORIZE THE ACCESS.

Patient Name (Print) Date	Name (Print of Authorized Rep) Date
Signature Date	Signature (Authorized Rep. & Relationship) Date

Phone 844-38SLEEP Fax 866-264-3890
www.sleephealthmd.com

Financial Policy

Patient Name:_____Date of Birth: _____

Thank you for choosing Sleep Health MD as your healthcare provider. We are committed to your treatment being a successful experience. Our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

WE ACCEPT MASTERCARD, VISA, DEBIT CARDS, DISCOVER, CHECKS, MONEY ORDERS AND CASH,

.

Non-Contracted / Indemnity Insurance Plans: We will bill your insurance company as a courtesy. We require you to pay in full at the time of service. Your insurance company will send payment directly to you.

Co-Payment – Your insurance carrier **requires** that all co-payments and deductible amounts be collected at time of service. A billing fee of
$35 will be added to your balance if you do not make your payment at the time of service.

Referrals - You are responsible for providing any required referrals or authorizations in advance of your appointment. We will estimate the amount due to the best of our ability.

Medicare: - As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% co- insurance and we must, by Medicare regulation, collect it. We will be happy to bill your secondary payer as well.

Secondary Insurers: - Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Divorce Decrees: - This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult regardless who the policy holder is for the insurance plan(s).

Missed Appointments: - There is a $35 missed appointment fee if you cancel or reschedule a clinic visit appointment with less than 24 hours advance notice or if you fail to arrive for your appointment.

Sleep Studies: - Any portion of the fee for sleep studies not covered by your insurance plan is due prior to the performance of the study

Sleep Study Cancellation or "No-Show": - Failure to appear and/or have not cancelled your scheduled study more than 48 hours prior to your study appointment will result in a charge of 10% of the study fee, up to $400.

Minor Patients: - The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

Your Personal and Insurance Information: - We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence.

Forms: - There is no charge for forms completed as part of an office visit. There may be a charge for filling out forms based on your medical records when it is not done at the time of an appointment. Fees vary depending upon the form, including school forms, child care forms, immunization cards, disability forms, etc.

Records and Copying: - There will be a $25 charge for copying materials from your chart when done other than at the time of a visit including the transfer of records to another facility.

Returned Check Fee: - There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will no longer accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed name of Patient or Responsible Party Relationship to Responsible Party

Phone/Text: 844-387-5337
SleepHealthMD.com

Patient Name: _____ *DOB:* _____ *ID:* _____

Sleep Health MD values your privacy. We also understand that there are circumstances wherein you, our patient, will want or need a person or entity other than yourself to communicate with our office on your behalf. By entering the name of a designee below (spouse, friend, family member, legal representative, etc.), we can aid you in that regard.

Unless and until you have listed a designated person/entity below, we will not be able to allow anyone other than you, the patient, access to any of the three areas listed below. Please update the fields below including the name(s), their relationship to you, and contact information of those you allow access to.

Name of Person/Entity	**SCHEDULING**	**BILLING**	**MEDICAL DECISION MAKING/ RECORDS**
Full name:	**YES NO**	**YES NO**	**YES NO**
Relationship:			
Mobile: Home:			
Full name:	**YES NO**	**YES NO**	**YES NO**
Relationship:			
Mobile: Home:			

I, _____, (printed patient name) authorize access by my signature below that the above listed person(s) has my permission to access the indicated areas of my health care.

Signature _____ Date_____

Witness signature _____ Date_____

Sleep Study Pre-Screening Questionnaire

Full Patient Name: _____

Date of Birth:_____ **Height & Weight**: _____

1. Do you have any infectious diseases? Yes ◯ No ◯

   If YES, please explain/describe: _____
2. Do you make frequent restroom trips during the night? Yes ◯ No ◯ _____
3. Do you need assistance getting to the restroom? Yes ◯ No ◯ _____
4. Do you use a cane or a wheelchair? Yes ◯ No ◯ _____
5. Do you need help in or getting out of bed? Yes ◯ No ◯ _____

**Please be aware that the Night Tech won't be able to help you get out of bed. We need to know if you'll needassistance. If you are injured or your mobility is affected, please state below.

_____.*****

6. Do you speak and understand English? Yes ◯ No ◯ _____
7. If mobility or language assistance is needed, you will need to bring a care giver to stay overnight.

   Who will be in attendance with you for the evening?

   Name/relationship: _____
8. For our pediatric patients 16 and under, a parent or legal guardian is **required** to stay overnight. **Optional for patients 17-18** Who will be in attendance with the child for the evening? **Limit 1** person due to space.
   Name/relationship: _____
9. Do you take sleep medications regularly? Yes ◯ No ◯

   If YES, what medication(s) and what dosage? _____
10. Are you on supplemental oxygen? Yes ◯ No ◯
11. Are you allergic to medical supplies such as latex or adhesives? Yes ◯ No ◯

    If YES, what medical supplies and what is the reaction? _____
12. Do you experience panic attacks? Yes ◯ No ◯
13. Are you claustrophobic or have anxiety w/ anything on face or w/small rooms? Yes ◯ No ◯
14. Do you have back problems/pain? Yes ◯ No ◯ If YES, where? _____
15. Have you had any recent medical procedures that may affect your comfort in bed? If YES, please explain:

    _____
16. What is your normal bed time?_____ Normal wake up time? _____
17. Emergency Contact Name: _____
    Relationship:_____Phone Number: _____
18. Do you have any questions, comments or concerns about the overnight test?

    _____

Authorization for Release of Medical Information

This form will be used to obtain medical records from another provider to Sleep Health MD

Patient's Name: _____

Date of Birth: _____

I hereby authorize Sleep Health MD to obtain my protected health information (PHI) as defined by Federal and State law. I understand that this authorization is voluntary.

The following information may be disclosed to Sleep Health MD:

☐ Medical Records
☐ Test Results
☒ Sleep Studies
☐ Other

*

The following section must be competed in full in order to obtain medical records

This Health Information may be disclosed by:

Name of the Provider: _____

Address: _____

_____

Phone: _____ Fax: _____

I understand that my health care will not be affected if I do not sign this form. This authorization will expire on

_____ or 5 years from the date of my signature below, whichever is earlier.

I also understand that I may revoke this authorization at any time by notifying Sleep Health MD in writing. I understand that my revocation of this authorization will not affect any actions taken by Sleep Health MD in reliance on this authorization prior to the time it received my revocation.

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extent minor could not have consented to the care).
☐ Guardian or conservator of an incompetent patient.
☐ Beneficiary or personal representative of deceased patient.

web: www.sleephealthmd.com phone: 844-387-5337 fax: 866-264-3890

Santa Cruz
1665 Dominican Way # 222
Santa Cruz, CA 95065

Watsonville
150 Carnation Dr. #4
Freedom, CA 95019

Monterey
101 Wilson Road #D
Monterey, CA 93940

Sunnyvale
260 S Sunnyvale Ave #6
Sunnyvale, CA 94087