

COMPREHENSIVE HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering the questions. Your partner may be able to assist you.

***Please remember to write your name at the top of each page.**

General Information *(This information will become part of your medical record and will remain confidential.)*

Patient Name:

Date:

(First)

(Middle)

(Last)

Address:

(Street)

(City)

(State)

(Zip)

Home Phone

Work Phone:

Cell Phone:

May we call you at work?

Email:

Best way to reach you?

Date of Birth:

Age:

Sex:

Male

Female

Height: _____

Weight: _____ lbs.

Marital Status:

☐ Single

☐ Widowed

☐ Divorced

☐ Married/Partner

SSN:

Occupation:

Emergency Contact:

Relationship:

Phone Number:

Referring Physician:

Primary Care Physician:

Cardiologist:

Pulmonologist:

List current medical conditions for which you are being treated.

Diagnosis

Year

Treating Physician

List all hospitalizations and surgeries you have had. *(Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Diagnosis

Year

Treating Physician

List medications you are currently taking. *(Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Medication

Reason

Dosage

How often

Please list any allergies we should be aware of:

Patient Name:

DOB:

DOS:

Health Questions *(Please answer the best you can)*Are you unable to sleep in a flat position due to shortness of breath? ☐ Yes ☐ NoDo you have a family history of snoring or other sleep disorders? ☐ Yes ☐ No

If yes, please describe:

Have you ever sustained a brain concussion, head injury or serious blow to the head? ☐ Yes ☐ NoDo you have spells or seizures? ☐ Yes ☐ NoDo you have high blood pressure? ☐ Yes ☐ NoHave you experienced a weight gain in the last year? ☐ Yes ☐ No

If yes, how much weight?

Has your shirt collar size increase recently? ☐ Yes ☐ No

If yes, by how much?

Do you smoke? ☐ Yes ☐ No

How many packs per day? How long have you smoked?

Have you quit smoking?

How many packs per day prior to quitting? How long did you smoked? Year quit?

Do you drink alcohol? ☐ Yes ☐ No

If yes, please estimate the number of drinks per day. (beer, wine, or liquor)

Do you drink caffeinated drinks? ☐ Yes ☐ No

If yes, please estimate the number of drinks per day. (sodas, coffee, or tea)

(Female) Have you gone through menopause? ☐ Yes ☐ No(Males) Have you experience any prostate issues? (i.e. Frequent urination) ☐ Yes ☐ No**Sleep Health Concerns & Habits**

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

Has this been a continuous problem? ☐ Comes and goes ☐ Occasional ☐ Frequent ☐ ConstantHow long has your sleep problem bothered you? ☐ Greater than 2yrs. ☐ 1-2 yrs. ☐ Several Months ☐ Last 3 Months ☐ Within the month

What time do you usually go to bed? Week Days: Weekends:

What time do you usually wake up? Week Days: Weekends:

How many hours of sleep do you usually get per night?

How long does it take you to fall asleep?

If you awake in the middle of the night, how long are you typically awake for?

Which shift do you work? (Check all that apply) ☐ Day ☐ Evening ☐ Night**Sleep Questions****Never** **Rarely** **Often** **Frequent** **Always**How often do you rotate shifts? ☐ ☐ ☐ ☐ ☐Does your job require overnight travel? ☐ ☐ ☐ ☐ ☐Do you drink alcohol at 6pm? ☐ ☐ ☐ ☐ ☐Do you drink caffeinated beverages after 6pm? ☐ ☐ ☐ ☐ ☐Do you suffer from a loss of libido? ☐ ☐ ☐ ☐ ☐(Males) Have you experienced difficulties with sexual functions? ☐ ☐ ☐ ☐ ☐

Patient Name:

DOB:

DOS:

Sleep Questions	Never	Rarely	Often	Frequent	Always
(Females) Does your sleep problem vary according to the stage of your menstrual cycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Females) Have you gone through menopause or had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you nap during the day or evening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed after a typical night's sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel sleepy during the day even when you have slept all night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed after a short nap?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you get sleepy while driving?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an accident or near-accident when driving, due to excessive sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to fight off the excessive sleepiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have memory or concentration problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience vivid dream-like scenes upon awakening or falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you are angry or laugh, do you ever feel weak, as though you might fall?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever unable to move or speak upon falling asleep or awakening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble falling asleep when you go to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you try to fall asleep does your mind race with thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you try to fall asleep do you feel pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a light sleeper, easily awakened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your sleep disrupted because of your bed partner or others in your household?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your snoring stop for brief periods during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your breathing sometimes stop during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your bed partner disturbed by your snoring?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you wake up choking or gasping for breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have night sweats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heartburn at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have nasal / sinus congestion at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have morning headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you a restless sleeper, tossing and turning at night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience any type of leg or back pain during the night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name:

DOB:

DOS:

Rate the Following from 1-10 (one being less 10 being most painful):

Facial Pain:

Headaches:

Jaw Pain:

Ear Pain:

Neck Pain:

Front/Back Head Pain:

Pain Spreads to
When Having Pain:

Temple
Sensitivity to Light
Vomiting

Back of Head
Nausea
Dizziness

Temporomandibular Joint Disorder (TMJ/TMD) & Pain Concerns

Symptom Questions	Right Side	Left Side		Right Side	Left Side
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Pain in facial area	<input type="checkbox"/>	<input type="checkbox"/>
Headaches					
Do you have pain around/behind the eyes?	<input type="checkbox"/>	<input type="checkbox"/>	Grating sound in joint	<input type="checkbox"/>	<input type="checkbox"/>
Pain in jaw	<input type="checkbox"/>	<input type="checkbox"/>	Subjective hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Pain in neck	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (vertigo)	<input type="checkbox"/>	<input type="checkbox"/>
Pain in shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Upset stomach- nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ringing sound in ears (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	Fullness, pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have pain in the ear?	<input type="checkbox"/>	<input type="checkbox"/>	blockage in ear/congestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain in forehead	<input type="checkbox"/>	<input type="checkbox"/>			

Other Pain Questions

Circle the kind of pain you have:	<input type="checkbox"/> Sharp	<input type="checkbox"/> Spreading	<input type="checkbox"/> Aching	<input type="checkbox"/> Deep
	<input type="checkbox"/> Dull	<input type="checkbox"/> Superficial	<input type="checkbox"/> Pulsating	<input type="checkbox"/> Burning
Is the pain?	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent		
Does the pain last for	<input type="checkbox"/> Minutes	<input type="checkbox"/> Hours	<input type="checkbox"/> All day	
Does the pain start Suddenly?		<input type="checkbox"/> Gradually		
Does the pain stop suddenly		<input type="checkbox"/> Gradually		
What time of the day or night is the pain the most severe				
How often do you have pain?	Monthly	Daily	Weekly	
What medication(s), if any, do you take to relieve the pain or have you tried?				

Does rest increase or decrease the pain?

Please describe any method of positioning the jaw or head that you have found for relieving pain:

Do any of the following normal daily activities cause pain? If yes, indicate where you feel pain.

<input type="checkbox"/> Yawning	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Brushing	<input type="checkbox"/> Moving shoulders
<input type="checkbox"/> Chewing	<input type="checkbox"/> Speaking	<input type="checkbox"/> Moving head	<input type="checkbox"/> Moving arms
<input type="checkbox"/> Singing	<input type="checkbox"/> Shouting	<input type="checkbox"/> Moving neck	<input type="checkbox"/> Moving trunk

Patient Name:

DOB:

DOS:

DYSFUNCTION

Can you open your mouth normally?	<input type="checkbox"/> Completely	<input type="checkbox"/> Partially
Do you ever open so wide your mouth locks open?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any of these sounds in the joint?	<input type="checkbox"/> Snapping	<input type="checkbox"/> Grating
If you have any of these problems is it frequent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS

Are your jaw muscles ever tired?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any injury to the jaw or face? If yes, explain.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you attribute the symptoms to any one incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had cortisone injected into the joint? If yes, when?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many injections? By whom?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you know if you clench your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has anyone mentioned that you grind your teeth (brux) at night during sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any other treatment for this problem? (If yes, explain-medicine, exercise, dental treatment)		
Have you had your bite adjusted by your dentist? (If yes, please explain when)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long have you been bothered by this problem?		
Is there anyone else in your family with a similar problem? (If yes, explain)		

Please describe briefly any changes in location or character of symptoms since this problem began

Do you chew gum?	Frequently	Moderately	Infrequently	Never
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Patient Name:

Date:

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to assess a person's daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times.

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:

*0 = would **never** doze or sleep.*

*1 = **slight** chance of dozing or sleeping*

*2 = **moderate** chance of dozing or sleeping*

*3 = **high** chance of dozing or sleeping*

<i>Situation</i>	<i>Chance of Dozing</i>
Sitting and Reading?	
Watching TV?	
Sitting inactive in a public place (ex: meeting, theater)?	
Being a passenger in a motor vehicle for an hour or more?	
Lying down to rest in the afternoon if circumstances permit?	
Sitting and talking to someone?	
Sitting quietly after lunch without alcohol?	
In a car, while stopped for a few minutes in traffic?	
	<i>TOTAL:</i>

Thank You!

AFFIDAVIT FOR INTOLERANCE TO PAP

Check the following that applies:

___ I have **NOT** attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons (check all that apply below):

___ I **HAVE** attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons (check all that apply below):

Amount of time PAP was used: _____ **Start Date** _____ **End Date** _____

___ Mask leaks

___ An inability to get the mask to fit properly

___ Discomfort or interrupted sleep caused by the presence of the device

___ Noise from the device disturbing sleep or bed partner's sleep

___ CPAP restricted movements during sleep

___ CPAP does not seem to be effective

___ Pressure on the upper lip causes tooth related problems

___ Latex allergy

___ Claustrophobic associations

___ An unconscious need to remove the PAP apparatus at night

___ Other (Please describe): _____

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Name: _____

Signature: _____ Date: _____

Informed Patient Consent

Patient Name: _____ DOB: _____

Welcome! We would like to give you a little more information about ourselves, and what to expect during our Craniofacial Treatment or Sleep Apnea Testing & Treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us. We would like to take this time to let you know you may receive a bill or insurance correspondence with Dedicated Sleep or Dr. James Siminski, Dr. Robert Gordon, Dr. Deepak Vadhan, Dr. Gregory Carnevale, Dr Barry Chase, Dr. Robert Garelick, Dr. Deepa Madhavan, Dr. Michael Steinberg, Dr Hedieh Samadi and/or Dr. Sarah Hubert's name on it. They are our Medical Directors that are partnered with our practice and will be supervising, coordinating, overseeing and monitoring all of your treatment for Sleep Apnea, or Craniofacial treatments with our office.

CONFIDENTIALITY AND PRIVACY NOTICE:

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization, bill for your treatment or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex,

and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

Insurance Authorization and Assignment: I request that payment of authorized medical benefits is made on my behalf directly to Dedicated Sleep, LLC. I authorize Dedicated Sleep, LLC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Dedicated Sleep, LLC. I hereby authorize that photocopies of this form to be valid as the original.

Patient Signature

Date

Notice of Privacy Practice

Effective January 1, 2024

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.

Questions? Please contact our Privacy Office at the address/ phone number at the end of this notice.

Who will follow this notice?

We provide health care to patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All contracted service partners for sleep and DME services.
- Any healthcare professional authorized to enter information into your chart, including practicing physicians and other credentialed individuals that participate with us in providing care and services.
- Any business associate or partner with whom we share health information.

Our Pledge to You:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in order to provide quality care and to comply with legal requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the current notice.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If there is a significant change in our policies, we will change our notice and post the new version in areas of the facilities generally accessible by patients and their families. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you with your consent or with the consent of others who are legally permitted to consent on your behalf for treatment (e.g., sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (e.g., sending billing information to your insurance company or Medicare); and to support health care operations (e.g., comparing patient data to improve treatment methods.)
- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, birth, death, abuse or neglect and domestic reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and other emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, e.g., regarding inmates in their custody, or in response to valid judicial or administrative orders.

- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you,
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, you or your personal representative have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after your date of service. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our Privacy Office listed below:

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office.

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

Acknowledgement of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement *

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

Office use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Medical Records Release Form

Patient's Name: _____ **Date of Birth:** _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Patient Signature: _____ **Date signed:** _____