The Center for Sleep Medicine
The Gold Standard in Sleep Care

Behavioral Sleep Medicine Program

Initial Evaluation Questionnaire

Important Instructions

1. **Please complete this packet and bring it with you to your first appointment.**

2. **If you need to cancel or reschedule your appointment, you *must* do so 24 hours before the appointment time (as stated in our practice policy). We usually dedicate an hour to your initial visit so it is important we know ahead of time if you will not be making your appointment. Cancellations in less than 24 business hours and "no shows" make it difficult for us to accommodate anyone else in this timeslot and lengthen the wait time for other patients.**

3. ***Starting the week before your scheduled appointment*, please maintain the sleep log on the next page to the best of your ability. If you obtain this packet less than a week before your appointment, please maintain the log starting the day you receive it.**

Introduction to Our Services

You have an appointment scheduled with a clinician (Ph.D/Psy.D) specializing in Behavioral Sleep Medicine (BSM). BSM is an area of sleep medicine offering research supported, non-medication treatments for a variety of sleep difficulties.

Your initial visit with a BSM Specialist will focus on evaluation of behavioral, psychological, and physiological factors contributing to your specific symptoms. Following the evaluation, we will develop a treatment plan tailored to your needs. We will begin our discussion of recommendations toward the end of the initial visit (as time permits) or at the second session. If we identify possible signs of a biologically-based sleep disorder warranting additional assessment, we will encourage you to consult with one of our sleep physicians or nurse practitioners regarding the medical concern.

Insomnia (frequent difficulty falling asleep or staying asleep) is the most common condition we address as BSM Specialists. We apply individualized Cognitive-Behavioral Therapy for Insomnia (CBT-I) based on the consensus recommendations of a number of key organizations including the National Institutes of Health, the American Academy of Sleep Medicine, and the American College of Physicians.

Other sleep problems we commonly help to resolve include circadian rhythm disorders (related to shift work, irregular or delayed sleep patterns, etc.), hypersomnia, nightmares, night eating, sleep or nighttime related fears and anxiety, and difficulty tolerating CPAP for sleep apnea.

A full course of treatment with a BSM Specialist usually spans several appointments -- on average between 3-5 visits. However, each individual is different and it may take some patients more or less time to meet their sleep-related goals.

If you have any questions regarding your appointment, please call 708-364-0261 and follow the prompts to speak with a member of our scheduling staff. Please also feel free to review the section on Behavioral Sleep Medicine on our website (www.sleepmedcenter.com), including the Frequently Asked Questions. We look forward to meeting with you!

Patient Name: ________________________ Date of Birth: ________________________

Initial Sleep Log								
For the week prior to your appointment, please complete the sleep log **each morning for the night before**. ******Please do not check the time (using a clock, phone, FitBit, etc.) in order to complete the log; instead, just provide a rough estimate based on what it felt like to you – all times will be considered approximate.***								
	Example	**Night 1**	**Night 2**	**Night 3**	**Night 4**	**Night 5**	**Night 6**	**Night 7**
Indicate the date and day of the week:	*10/5 Monday*							
A. What time did you physically get into bed (last night)?	*9:45 PM*							
B. At about what time did you engage sleep effort or "try" to go to sleep? (i.e., when you turned out the light, put your head on the pillow, stopped reading)	*10:00 PM*							
C. Estimate how long it took you to fall asleep once trying to do so:	*45 min.*							
D. Once asleep, about how many times did you wake (not including the final time)?	*2*							
E. Estimate the total amount of time you were awake during all of your awakenings combined:	*80 min.*							
F. At about what time did you wake for the final time (before getting out of bed)?	*7:00 AM*							
G. What time did you get out of bed to rise for the day?	*7:30 AM*							
H. How rested did you feel when getting out of bed? 1 = "not at all rested" to 10 = "very rested"	*3*							
I. How rested did you feel one hour after getting out of bed? 1 = "not at all rested" to 10 = "very rested"	*5*							
J. Please rate your overall daytime functioning yesterday: 1 = "very poor" to 10 = "excellent"	*6*							
K. Estimate the total amount of time you napped yesterday (intentionally or unintentionally) and when these naps occurred:	*60 min. 1:30pm*							
L. List any over-the-counter or prescription sleep medications you took last night and the dosage:	*zolpidem 5 mg*							

Initial Evaluation Questionnaire

Patient Name: ________________________________ Date of Birth: _______________ Date: _______________

Sleep Problem and Severity Assessment

Below are questions which help us assess the nature and severity of your sleep problem. We want to know about the current nature of your difficulty – meaning, *within the last two weeks:*

1. Rate the *current* severity of your sleep problem:

	Not Applicable	Mild	Moderate	Severe	Very Severe
a. Difficulty falling asleep	☐	☐	☐	☐	☐
b. Difficulty staying asleep	☐	☐	☐	☐	☐
c. Problems waking too early	☐	☐	☐	☐	☐
d. Poor sleep quality	☐	☐	☐	☐	☐
e. Sleeping too little or too much *(please circle)*	☐	☐	☐	☐	☐
f. Falling asleep during the day (e.g. napping)	☐	☐	☐	☐	☐
g. Problematic sleep schedule (e.g. irregular pattern, sleeping in too late)	☐	☐	☐	☐	☐
h. Unwanted behavior during sleep (e.g. sleepwalking)	☐	☐	☐	☐	☐
i. Nightmares or vivid dreams *(please circle)*	☐	☐	☐	☐	☐
j. Other (*please specify*): ________________________	☐	☐	☐	☐	☐

2. How long does it usually take you to fall asleep? _____________ *minutes/hours*

3. How many times do you wake up during the night? _____________

4. How long are you usually awake after waking up at night? _____________ *minutes/hours*

5. How often during a week do you nap or doze? _____________

6. On how many nights during an average week do you experience sleep difficulties? __________________

	Not at All	A Little	Some	Much	Very Much
7. How dissatisfied are you with your *current* sleep pattern?	☐	☐	☐	☐	☐
8. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?	☐	☐	☐	☐	☐
9. How worried/distressed are you about your *current* sleep problem?	☐	☐	☐	☐	☐
10. To what extent do you consider your problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) *currently*?	☐	☐	☐	☐	☐

11. How long have you experienced sleep difficulties? _____________________________

12. Was there any event or life situation that seems to have occurred around the time your sleep difficulties emerged? Is there anything you feel caused or worsened your sleep difficulty? Yes ☐ No ☐

If yes, please briefly describe: ____

____

Contributing Factors

Rate the extent to which you feel the following factors may contribute to your sleep difficulties:

	Not at All	A Little	Some	Much	Very Much
a. Mental activity (i.e., mind won't "shut off," racing thoughts, worry about sleep)	☐	☐	☐	☐	☐
b. Physical discomfort (e.g., pain, muscle tension)	☐	☐	☐	☐	☐
c. Poor sleep habits (e.g., heavy caffeine use, spending waking hours in bed)	☐	☐	☐	☐	☐
d. Mood (e.g. depression, anxiety)	☐	☐	☐	☐	☐
e. Natural aging (e.g., menopause, prostate issues)	☐	☐	☐	☐	☐
f. A variable sleep schedule (i.e., due to shift work or lifestyle)	☐	☐	☐	☐	☐
g. Personal stressors (e.g., relationships, family domain)	☐	☐	☐	☐	☐
h. Work stressors (e.g., work demands, job security)	☐	☐	☐	☐	☐
i. Weight gain or loss	☐	☐	☐	☐	☐
j. Medication(s)	☐	☐	☐	☐	☐
k. Medical condition(s)	☐	☐	☐	☐	☐
l. Travel schedule (e.g., jet lag)	☐	☐	☐	☐	☐
m. Other *(please specify)*: ______________________________	☐	☐	☐	☐	☐

Current and Prior Treatment Efforts

Please help us understand what kinds of approaches you have tried in the past or are currently using to address your sleep problem:

	Past Use	Current Use
1. Over-the-Counter sleep aids (e.g., Tylenol PM, Unisom, ZzzQuil)	☐	☐
2. Prescription sleep aids:		
a. Lunesta (eszopiclone)	☐	☐
b. Ambien (zolpidem)	☐	☐
c. Ambien CR (zolpidem ER)	☐	☐
d. Rozerem (ramelteon)	☐	☐
e. Sonata (zaleplon)	☐	☐
f. Belsomra (suvorexant)	☐	☐
g. Trazodone	☐	☐
h. Benzodiazepines (e.g., lorazepam, Xanax, Klonopin)	☐	☐
i. Seroquel (quetiapine)	☐	☐
j. Minipress (prazosin)	☐	☐
k. Other prescription medications:	☐	☐
3. Alcohol	☐	☐
4. Melatonin	☐	☐
5. Herbal supplements/tea (e.g., gingko biloba, valerian root)	☐	☐
6. Other controlled substances (e.g., marijuana)	☐	☐
7. Self-help literature (e.g., books, pamphlets about insomnia)	☐	☐
8. Relaxation exercises/yoga/meditation	☐	☐
9 Cognitive Behavioral Therapy (CBT)	☐	☐
10. Psychotherapy/counseling	☐	☐
11. Other (acupuncture, massage, etc.- *please specify)* ______________________	☐	☐

Beliefs and Attitudes About Your Sleep (DBAS – 16)

Beliefs and attitudes about sleep both shape, and are shaped by, sleep difficulties. Below are several statements about sleep related beliefs and attitudes. Please indicate to what extent you personally *agree* or *disagree* with each statement. There are no correct or incorrect answers.

		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree	
1.	I need 8 hours of sleep to feel refreshed and function well during the day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	When I don't get the amount of sleep I need, I have to catch up the next day by napping or on the next night by sleeping longer.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	I am concerned that chronic sleep difficulties may have serious consequences for my physical health.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	I am worried that I may lose control over my abilities to sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	After a poor night's sleep, I know that it will interfere with my daily activities on the next day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	In order to be alert and function well during the day, I am better off taking a sleeping pill rather than having a poor night's sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	When I feel irritable, depressed or anxious during the day, it is because I did not sleep well the night before.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	When I sleep poorly on one night, I know it will disturb my sleep schedule for the whole week.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	Without an adequate night's sleep, I can hardly function the next day.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	I can't ever predict whether I'll have a good or poor night's sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	I have little ability to manage the negative consequences of disturbed sleep.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12.	When I feel tired, have no energy, or just seem not to function well during the day, it is generally because I did not sleep well the night before.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13.	I believe my sleep difficulties are essentially the result of a chemical imbalance.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14.	I feel my sleep difficulties are ruining my ability to enjoy life and prevent me from doing what I want.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15.	A "nightcap" before bedtime is a good solution to sleep problems.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16.	It usually shows in my physical appearance when I haven't slept well.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

General Anxiety (GAD – 7) and Brief Patient Health Questionnaire ™ (PHQ)

How we feel in terms of mood, stress and anxiety can both cause and contribute to sleep difficulties. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability.

1. Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
b. Not being able to sleep or control worrying	☐	☐	☐	☐
c. Worrying too much about different things	☐	☐	☐	☐
d. Trouble relaxing	☐	☐	☐	☐
e. Being so restless that it is hard to sit still	☐	☐	☐	☐
f. Becoming easily annoyed or irritable	☐	☐	☐	☐
g. Feeling afraid, as if something awful could happen	☐	☐	☐	☐
h. Little interest or pleasure in doing things	☐	☐	☐	☐
i. Feeling down, depressed or hopeless	☐	☐	☐	☐
j. Trouble falling or staying asleep; sleeping too much	☐	☐	☐	☐
k. Feeling tired or having little energy	☐	☐	☐	☐
l. Poor appetite or overeating	☐	☐	☐	☐
m. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
n. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
o. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
p. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Brief PHQ (continued)

2. In the ***last 4 weeks***, how much have you been bothered by any of the following problems?

	Not Applicable	Not Bothered	Bothered a Little	Bothered a Lot
a. Worrying about your health	☐	☐	☐	☐
b. Your weight or how you look	☐	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐	☐
d. Difficulties with your husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐	☐
f. Stress at work, outside of the home, or at school	☐	☐	☐	☐
g. Financial problems or worries	☐	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you *in the past* – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐	☐
3. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act?	☐	☐	☐	☐

4. What is the most stressful thing in your life right now? ______________________

____

____

Medical Conditions and Medications

Please list any medical conditions you may have and any medications you are currently taking:

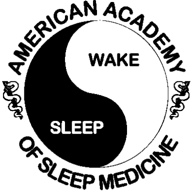
____

____

____

____

____



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Authorization of Benefits

I hereby authorize payment of medical benefits for services rendered by The Center for Sleep Medicine directly to Associates in Sleep Medicine, L.L.C. and Sigma Health P.C. I further authorize the release of any medical information required by Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C. to process an insurance claim on my behalf. A copy of this authorization will be sent to my insurance company if requested. The original authorization will be kept on file by Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C.

In case of an insurance company's refusal to pay Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C., I will assume full responsibility for the payment. If my insurance company should pay benefits directly to me for services provided by Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C., I will forward all checks from my insurance company to Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C.

I will notify Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C. immediately of any change in my insurance coverage.

I further authorize the release of any information necessary to process such claims, including medical record information from a doctor or hospital. I authorize Associates in Sleep Medicine, L.L.C. (d/b/a The Center for Sleep Medicine) and Sigma Health P.C. to allow confidential review of the file of my treatment, if requested by any state, federal, or accreditation agency.

______________________________ ____________________
Printed Name of Patient Date of Birth

______________________________ ____________________
Signature of Patient Date

OR

____
Printed Name of Parent/Guardian

______________________________ ____________________
Signature of Parent/Guardian Date

The Center for Sleep Medicine

HIPAA Notice of Privacy Practices ("Notice")

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT FURTHER DETAILS HOW YOU OR YOUR PERSONAL REPRESENTATIVE MAY GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

If you have any questions about this Notice please contact our privacy contact, Shilo Velez ("Privacy Contact"), at (708) 364-0261. This Notice describes how our practice and our health care professionals, employees, volunteers, trainees and staff may use and disclose your medical information to carry out treatment, payment or health care operations and for other purposes that are described in this Notice. We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. This Notice applies to all records of your care generated by this practice.

This Notice also describes your right to access and control your medical information. This information about you includes demographic information that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services. Typically your medical information will include symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment.

We are required by law to protect the privacy of your medical information and to follow the terms of this Notice. We may change the terms of this Notice at any time. The new Notice will then be effective for all medical information that we maintain at that time and thereafter. We will provide you with any revised Notice if you request a revised copy be sent to you in the mail or if you ask for one when you are in the office.

I. Uses and Disclosures of Protected Health Information.

Your medical information may be used and disclosed for purposes of treatment, payment and health care operations. The following are examples of different ways we use and disclose medical information. **These are examples only.**

(a) Treatment:

We may use and disclose medical information about you to provide, coordinate, or manage your medical treatment or any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your medical information. For example, we could disclose your medical information to a home health agency that provides care to you. We may also disclose medical information to other physicians who may be treating you, such as a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information to another physician or health care provider, such as a laboratory.

(b) Payment:

We may use and disclose medical information about you to obtain payment for the treatment and services you receive from us. For example, we may need to provide your health insurance plan information about your treatment plan so that they can make a determination of eligibility or to obtain prior approval for planned treatment. For example, obtaining approval for a hospital stay may require that relevant medical information be disclosed to the health plan to obtain approval for the hospital admission.

(c) Healthcare Operations:

We may use or disclose medical information about you in order to support the business activities of our practice. These activities include, but are not limited to, reviewing our treatment of you, employee performance reviews, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your medical information to remind you of your next appointment.

We may share your medical information with third party "business associates" that perform activities on our behalf, such as billing or transcription for the practice. Whenever an arrangement between our office and a business associate involves the

use or disclosure of your medical information, we will have a written contract that contains terms that asks the "business associate" to protect the privacy of your medical information.

We may use or disclose your medical information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your medical information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact **our Privacy Contact** to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our **Privacy Contact** to request that these fundraising materials not be sent to you.

(d) Health Information Exchange:

We, along with certain other health care providers and practice groups in the area, may participate in a health information exchange ("Exchange"). An Exchange facilitates electronic sharing and exchange of medical and other individually identifiable health information regarding patients among health care providers that participate in the Exchange. Through the Exchange we may electronically disclose demographic, medical, billing and other health-related information about you to other health care providers that participate in the Exchange and request such information for purposes of facilitating or providing treatment, arrangement for payment for health care services or otherwise conducting or administering health care operations.

II. Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object.

We may use and disclose your medical information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your medical information. If you are not present or able to agree or object to the use or disclosure of the medical information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the medical information that is relevant to your health care will be disclosed.

(a) Others Involved in Your Healthcare:

Unless you object, we may disclose to a member of your family, a relative, or close friend your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your medical information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

(b) Emergencies:

We may use or disclose your medical information for emergency treatment. If this happens, we shall try to obtain your consent as soon as reasonable after the delivery of treatment. If the practice is required by law to treat you and has attempted to obtain your consent but is unable to do so, the practice may still use or disclose your medical information to treat you.

(c) Communication Barriers:

We may use and disclose your medical information if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and, in our professional judgment, you intended to consent to use to use or disclosure under the circumstances.

III. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object.

We may use or disclose your medical information in the following situations without your consent or authorization. These situations include:

(a) Required By Law:

We may use or disclose your medical information when federal, state or local law requires disclosure. You will be notified of any such uses or disclosure.

(b) Public Health:

We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. This disclosure will be made for the purpose of controlling disease, injury or disability.

(c) Communicable Diseases:

We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

(d) Health Oversight:

We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure. These activities are necessary for the government agencies to oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

(e) Abuse or Neglect:

We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information to the governmental entity authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence as is consistent with the requirements of applicable federal and state laws.

(f) Food and Drug Administration:

We may disclose your medical information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

(g) Legal Proceedings:

We may disclose medical information in the course of any judicial or administrative proceeding, when required by a court order or administrative tribunal, and in certain conditions in response to a subpoena, discovery request or other lawful process.

(h) Law Enforcement:

We may disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (i) responding to a court order, subpoena, warrant, summons or otherwise required by law; (ii) identifying or locating a suspect, fugitive, material witness or missing person; (iii) pertaining to victims of a crime; (iv) suspecting that death has occurred as a result of criminal conduct; (v) in the event that a crime occurs on the premises of the practice; and (vi) responding to a medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

(i) Coroners, Funeral Directors, and Organ Donors:

We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to funeral directors as necessary to carry out their duties.

(j) Research:

We may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board ("IRB") or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate, written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by

law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

(k) Criminal Activity:

Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

(l) Organ and Tissue Donation:

If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

(m) Military Activity and National Security.

If you are a member of the armed forces, we may use or disclose medical information, (i) as required by military command authorities; (ii) for the purpose of determining by the Department of Veterans Affairs of your eligibility for benefits; or (iii) for foreign military personnel to the appropriate foreign military authority. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the protective services to the President or others legally authorized.

(n) Workers' Compensation:

We may disclose your medical information as authorized to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illness.

(o) Inmates:

We may use or disclose your medical information if you are an inmate of a correctional facility and our practice created or received your health information in the course of providing care to you.

(p) Required Uses and Disclosures:

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500, et seq. seq.

IV. The Following Is a Statement of Your Rights with Respect to Your Medical Information and a Brief Description of How You May Exercise These Rights.

(a) You have the right to inspect and copy your medical information.

This means you may inspect and obtain a copy of medical information about you that has originated in our practice. We may charge you a reasonable fee for copying and mailing records. To the extent we maintain any portion of your PHI in electronic format, you have the right to receive such PHI from us in an electronic format. We will charge no more than actual labor cost to provide you electronic versions of your PHI that we maintain in electronic format.

After you have made a written request to our Privacy Contact at the following address: 10640 W. 165th St. Orland Park, Il 60467, we will have thirty (30) days to satisfy your request. If we deny your request to inspect or copy your medical information, we will provide you with a written explanation of the denial.

You may not have a right to inspect or copy psychotherapy notes. In some circumstances, you may have a right to have the decision to deny you access reviewed. Please contact the Privacy Contact if you have any questions about access to your medical record.

(b) You have the right to request a restriction of your medical information.

You may ask us not to use or disclose part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. You must state in writing the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict information sent to your

health plan or insurer for products or services that you paid for solely out-of-pocket and for which no claim was made to your health plan or insurer.

(c) **<u>We are not required to agree to your request</u>.** If we believe it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted; provided, however, we must agree to your request to restrict disclosure of your medical information if: (i) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (ii) the information pertains solely to a health care item or service for which you (and not your health plan) have paid us in full. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. Your written request must be specific as to what information you want to limit and to whom you want the limits to apply. The request should be sent, in writing, to our Privacy Contact.

(d) **<u>You have the right to request to receive confidential communications from us at a location other than your primary address</u>.**

We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Contact.

(e) **<u>You may have the right to have us amend your medical information</u>.**

If you feel that medical information we have about you is incorrect or incomplete, you may request we amend the information. If you wish to request an amendment to your medical information, please contact our Privacy Contact, in writing to request our form *Request to Amend Health Information.* In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us.

(f) **<u>You have the right to receive an accounting of disclosures we have made, if any, of your medical information</u>.**

This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, family members or friends involved in your care, or for notification purposes. To receive information regarding disclosures made for a specific time period no longer than six (6) years and after April 14, 2003, please submit your request in writing to our Privacy Contact. We will notify you in writing of the cost involved in preparing this list. To the extent we maintain your PHI in electronic format, you may request an accounting of all electronic disclosures of your PHI for treatment, payment, or healthcare operations for the preceding three (3) years prior to such request.

(g) **<u>Uses and Disclosures of Protected Health Information Based upon Your Written Authorization</u>.**

Other uses and disclosures of your medical information not covered by this Notice or required by law will be made only with your written authorization. For example, most uses and disclosures of psychotherapy notes; PHI for marketing purposes; that constitute a sale of PH and other than those described in this Notice, require authorization. You may revoke this authorization at any time, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the prior authorization.

(h) **<u>Right to be Notified of a Breach.</u>**

You have the right to be notified in the event that our practice (or a Business Associate of ours) discovers a breach of unsecured protected health information.

(h) **<u>Complaints</u>:**

You may complain to us or to the Secretary Of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact, in writing. We will not retaliate against you for filing a complaint.

By signing this form, you acknowledge receiving this Notice and that you were afforded an opportunity to ask questions related to the content herein.

Signature of Patient ____ Date____________________

Print Name of Patient ___________________________________

E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Associates in Sleep Medicine/The Center for Sleep Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

______________________________	______________
Print Patient Name	Patient DOB
______________________________	______________
Signature of Patient or Guardian	Date
______________________________	
Relationship to Patient	

The Center for Sleep Medicine

The Gold Standard in Sleep Care

Telephone Consent Form

Patient Name: ____

Patient Date of Birth: _________________________________

Phone Numbers:		**Primary:** (Select)	**Secondary:** (Select)
Home	______________________	____	____
Work	______________________	____	____
Cell	______________________	____	____
Emergency Contact	______________________		

Patient E-mail* address: ____

May we speak with family members?

Spouse/Partner:	Yes ____	No ____
Child:	Yes ____	No ____
Other: _____________________	Yes ____	No ____

_______________________________ **Patient/Guardian Signature**

________________________ **Date**

***E-mail Privacy Policy**

By providing your email address you agree to be contacted by The Center for Sleep Medicine and its affiliates. The Center for Sleep Medicine will not sell or disclose your email address and will be used for the sole purpose of communicating with you regarding information about your healthcare needs and any other business related directly with The Center for Sleep Medicine and its affiliates.

The Center for Sleep Medicine
The Gold Standard in Sleep Care

Cancellation/No Show Policy
for Doctor Appointments and Sleep Studies

1. **Cancellation/No Show Policy for Doctor Appointments**
   A $75 fee will be charged for all “no shows” or cancellations without 24 business hours notification; this fee is not covered by your insurance company or Medicare.
2. **Late Arrivals for Scheduled Appointments**
   If you arrive 15 minutes or more past your scheduled time, you may or may not be seen at the discretion of the provider.
3. **Cancellation/No Show Policy for Sleep Studies**
   If you need to cancel your scheduled sleep study, you must contact the sleep center 24 business hours in advance. Please call by 5:00 p.m. on Friday to cancel a Saturday/Sunday/Monday night study.

   A $250 fee will be charged for all “no shows” or cancellations without 24 business hours notification; this fee is not covered by your insurance company or Medicare.

Revised 6/1/17