# THE CENTER FOR SLEEP MEDICINE

**SLEEP SYMPTOM AND MEDICAL QUESTIONNAIRE**

## IDENTIFYING INFORMATION

First and Last Name: _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Gender: _____ Marital Status: _____ Weight: _____ lbs. Height: _____ ft./in.

## PRESENTING PROBLEM

Please describe your main complaint by checking one or more of the items below and providing a brief explanation of how you experience these difficulties:

1. ☐ I have trouble falling asleep
   ☐ I'm sleepy all day
   ☐ I have unwanted behaviors when I'm asleep

2. Explain: _____

_____

## SLEEP SCHEDULE

Please describe your *typical* sleep schedule:

1. During the *work week*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
2. On *days off/weekends*, you go to bed at: _____ (AM or PM?), rising at: _____ (AM or PM?).
3. When do you usually feel at your best? ☐ Morning ☐ Evening
4. How long does it usually take you to fall asleep? _____ (Indicate minutes or hours)
5. How many times do you wake up during the night? _____
6. How long are you usually awake when waking at night? _____ (Indicate minutes or hours)

## HEALTH HABITS AFFECTING SLEEP

| | Never | Little | Weekly | 2-3 times/wk | Daily |
|---|---|---|---|---|---|
| 1. How often do you *usually* nap? | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. How often do you *usually* exercise? | ☐ | ☐ | ☐ | ☐ | ☐ |

3a. Do you smoke cigarettes *or* have you smoked in the past? ☐ Yes ☐ No

b. If Yes: How long have you smoked? _____ (Indicate years or months)

c. How much do you smoke each day? _____ (Indicate cigarettes or packs)

d. If you've quit, when did you stop? _____ (Indicate years or months)

4a. Do you drink alcohol? ☐ Yes ☐ No

b. If Yes, at what time(s), and how much? _____

5a. Do you drink anything with caffeine regularly? ☐ Yes ☐ No
*(this includes: coffee, tea, soda/pop, energy drinks)*

b. If Yes, what do you drink and at what time(s) during the day or night? _____

_____

## SLEEP SYMPTOM DESCRIPTION

Please help us understand the nature of your sleep difficulties. Check all statements that apply:

1. ☐ I have been told that I snore loudly.
2. ☐ My bed covers are very messed up in the morning.
3. ☐ I usually toss and turn at night and am a restless sleeper.
4. ☐ I have been told that I kick and poke my bed partner during sleep.
5. ☐ My arms or legs move during sleep, sometimes waking me up.
6. ☐ I have hallucinations or dreams while falling asleep or waking up.
7. ☐ I sometimes awaken with a choking sensation.
8. ☐ I have been told that I stop breathing while asleep.
9. ☐ I have fallen out of bed.
10. ☐ I frequently wake from my sleep at night.
11. ☐ I have felt paralyzed or unable to move when waking up.
12. ☐ I have felt paralyzed or unable to move when falling asleep.
13. ☐ I awaken suddenly feeling fearful, anxious, tense or depressed.
14. ☐ When I awaken during the night, I frequently use the bathroom
15. ☐ I feel the quality of my sleep is unsatisfactory.
16. ☐ I have been told that my arms or legs twitch and jerk during my sleep.
17. ☐ I frequently get cramps in my legs.
18. ☐ I sometimes wake up with a headache.
19. ☐ I have trouble falling asleep at night.
20. ☐ I have trouble falling back to sleep when I wake up during the night.
21. ☐ Some nights I never get to sleep no matter how hard I try.
22. ☐ When I try to go to sleep my mind races with thoughts.
23. ☐ I often sleep better in a hotel or at a family member's home.
24. ☐ I have had accidents, or near accidents because of being sleepy or falling asleep.
25. ☐ The muscles in my legs feel tense, and moving my legs and feet relieves the tension.
26. ☐ I feel pain when I try to fall asleep or pain wakes me up at night.
27. ☐ I often need to take sleep pills to fall asleep.
28. ☐ I have a creeping crawling feeling in my legs when I lie down or relax.
29. ☐ I am a very light sleeper, I am awakened easily.
30. ☐ My sleep is disturbed because of my bed partner.
31. ☐ I have had occasions when I feel sudden weakness in my legs.
32. ☐ I can fall asleep at any time, regardless of the situation.
33. ☐ I feel that I sleep too much.
34. ☐ I feel that I sleep too little.
35. ☐ I generally feel sleepy all day.

## SLEEPINESS

Please indicate how likely you are to fall asleep in each situation:

| | | No chance (0) | Slight chance (1) | Moderate chance (2) | High chance (3) |
|---|---|---|---|---|---|
| 1. | Sitting and reading | ☐ | ☐ | ☐ | ☐ |
| 2. | Watching TV | ☐ | ☐ | ☐ | ☐ |
| 3. | Sitting inactive in a public place (e.g. theater, meeting) | ☐ | ☐ | ☐ | ☐ |
| 4. | As a passenger in a car for an hour without a break | ☐ | ☐ | ☐ | ☐ |
| 5. | Lying down to rest in the afternoon when circumstances permit | ☐ | ☐ | ☐ | ☐ |
| 6. | Sitting and talking to someone | ☐ | ☐ | ☐ | ☐ |
| 7. | Sitting quietly after a lunch without alcohol | ☐ | ☐ | ☐ | ☐ |
| 8. | In a car, while stopped for a few minutes in traffic | ☐ | ☐ | ☐ | ☐ |

**For each question, please CIRCLE the number that best describes your answer.**
**Please rate the *CURRENT* (i.e., *LAST 2 WEEKS*) *SEVERITY* of your insomnia problem(s).**

| Insomnia Problem | None | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|---|
| **1.** Difficulty falling asleep | **0** | **1** | **2** | **3** | **4** |
| **2.** Difficulty staying asleep | **0** | **1** | **2** | **3** | **4** |
| **3.** Problem waking up too early | **0** | **1** | **2** | **3** | **4** |

**4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?**

| Very Satisfied | Satisfied | Moderately Satisfied | Dissatisfied | Very Dissatisfied |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?**

| Not at all Noticeable | A Little | Somewhat | Much | Very Much Noticeable |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**6. How WORRIED/DISTRESSED are you about your current sleep problem?**

| Not At All Worried | A Little | Somewhat | Much | Very Much Worried |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?**

| Not At All Interfering | A Little | Somewhat | Much | Very Much Interfering |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

## YOUR MEDICAL CONDITIONS

1. Please indicate if you have, or have had, any of the following conditions?

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Thyroid disease | ☐ Large tonsils or adenoids |
| ☐ Arthritis | ☐ Liver disease | ☐ Deviated septum, crooked/broken nose |
| ☐ Chronic pain | ☐ Undergoing dialysis | ☐ Dizziness or passing out |
| ☐ Fibromyalgia | ☐ Multiple sclerosis | ☐ Irregular heart beat |
| ☐ Tuberculosis | ☐ Acid reflux | ☐ High blood pressure |
| ☐ Hepatitis | ☐ Sinus problems | ☐ Anxiety, nervousness or panic attacks |
| ☐ Heart problems | ☐ Large uvula | ☐ Depression |
| ☐ Pacemaker | ☐ Morning headaches | ☐ Menopause or perimenopause |
| ☐ Defibrillator | ☐ Chronic headaches | ☐ Irritable bowel, ulcers, stomach pain |
| ☐ Emphysema | ☐ Seizures | ☐ Cancer (type): _____ |
| ☐ Asthma | ☐ Stroke | ☐ Other: _____ |

2. Please describe any other medical conditions or current physical complaint: _____

3. Please list all medications that you take.

4. Have you undergone upper airway or sinus surgeries? If yes, please describe any surgeries performed on the nose, mouth, throat, neck or head: ☐ Yes ☐ No

5. Please list any allergies: _____

## FAMILY HISTORY

Does anyone else in your family have sleep problems? ☐ Yes ☐ No

If yes, describe their relationship to you (e.g. mother, father, sister) and their condition:

## OTHER INFORMATION

1. Please describe any other information you feel may affect your sleep, or your treatment with us:

Patient Name: _____

| Pre-Study Adult Sleep Log | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| For the week prior to your appointment, please complete the following sleep log **each day** as accurately as you can. | | | | | | | | |
| | **Sample** | **Night 1** | **Night 2** | **Night 3** | **Night 4** | **Night 5** | **Night 6** | **Night 7** |
| Indicate date and day of the week: | **10/5 Monday** | | | | | | | |
| What time did you get into bed? | **10:30 pm** | | | | | | | |
| What time did you get up for the day? | **6:30 am** | | | | | | | |
| Approximately how many hours did you sleep last night? | **7.5 hrs** | | | | | | | |
| What was the quality of your sleep? (1-5)<br>1 = Very Poor; 2 = Poor; 3 = Fair; 4 = Good; 5 = Very Good | **2** | | | | | | | |
| Bed partner's assessment of your sleep: | **Loud snoring** | | | | | | | |
| How long did it take you to fall asleep? | **5 min** | | | | | | | |
| How many times did you awaken? | **5** | | | | | | | |
| Total time awake after sleep onset? | **25 min** | | | | | | | |
| List the time and duration of any naps you took during the day? | **4:30 pm. (2 hours)** | | | | | | | |
| List any over-the-counter or prescription sleep medication you took last night: | **None** | | | | | | | |
| Other information about your sleep: | **Tried not to nap, but had to** | | | | | | | |

The Center for Sleep Medicine

*An Employee-Owned Company*

The difference between going to bed, and going to sleep.™

## Cancellation/No Show Policy

1. Cancellation/No Show Policy for Provider Appointments - A **$75 fee** will be charged for all 'no shows' or cancellations without **24 business hours** notification; this administrative fee is not a covered healthcare service and is not billed to insurance

2. Late Arrivals for Scheduled Appointments - If you arrive 7 minutes or more past your scheduled 15-minute appointment time, you may or may not be seen at the discretion of the provider. If you arrive 15 minutes or more past your scheduled 30-minute appointment time, you may or may not be seen at the discretion of the provider. If you arrive 30 minutes or more past your scheduled 60-minute appointment 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 5:00pm on Friday to cancel a Saturday, Sunday, or Monday night study. A **$250 fee** will be charged for all 'no shows' or cancellations without 24 business hours notification; this administrative fee is not a covered healthcare service and is not billed to insurance.

## ePrescribing 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 reduced medication errors and enhances patient safety. The Medicare Modernization Act **[MMA]** of 2003 listed standards that must 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.
- Medical history transactions - Provides the physician with the 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.

You agree that Associates in Sleep Medicine, L.L.C. [DBA The Center for Sleep Medicine], Advanced Health Services, Inc., and Sigma Health, S.C. can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefits payors for treatment purposes.

## Financial Policy

To better serve our patients, we understand the need for clear communication of our financial policies. Please understand that payment for service is an important part of our professional relationship and we strive to be stewards of your healthcare dollars. Prior to receiving services/products, we request any applicable payments to be satisfied that are the responsibility of the patient. We accept Visa, MasterCard, Discover, and American Express. You remain responsible for non-covered services, patient responsibility amounts, and claims denied due to failure to meet plan requirements, benefit exclusions, or incomplete information provided by the patient.

*Deductibles, co-payments, and coinsurance will be collected at the time services are rendered.* If you are unable to pay for your services on the date of your appointment, your appointment may be rescheduled. Any credit card surcharge will not exceed the actual cost of card acceptance or applicable legal limits. No surcharge applies to FSA/HSA and debit cards.

## 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. [D/B/A The Center for Sleep Medicine], Advanced Health Services, Inc., and Sigma Health S.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], Advanced Health Services, Inc., and Sigma Health S.C. to process an insurance claim on my behalf. A copy of this authorization will be kept on file by Associates in Sleep Medicine, L.L.C. [D/B/A The Center for Sleep Medicine], Advanced Health Services, Inc., and Sigma Health, S.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], Advanced Health Services, Inc., and Sigma Health, S.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], Advanced Health Services, Inc., 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], Advanced Health Services, Inc., and Sigma Health, S.C. I will notify Associates in Sleep Medicine, L.L.C. [D/B/A The Center for Sleep Medicine], Advanced Health Services, Inc., and Sigma Health, S.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], Advanced Health Services, Inc., and Sigma Health, S.C. to allow confidential review of the file of my treatment, if requested by any state, federal, or accreditation agency. I request payment of authorized Medicare benefits be made on my behalf directly to the provider for services furnished. We kindly request that you provide your most current insurance information at the time of check-in to ensure accuracy and for payment of benefits. If your insurance has changed, and we do not have the most recent insurance information on file, you will be responsible for any and all charges that may have been covered by your insurance. I consent to and authorize Associates in Sleep Medicine, L.L.C. [D/B/A The Center for Sleep Medicine], Advanced Health Services, Inc., and Sigma Health S.C. to remotely monitor my PAP device (CPAP/APAP/Bi-Level/ASV) to help ensure health compliance and payor requirements for therapy.

Remote patient monitoring (RPM) is a service in which healthcare companies monitor patients outside the traditional care setting using digital medical devices. I understand Remote Patient Monitoring services involve the collection and review of electronically transmitted physiologic or device data. These services may be billed to Medicare or other insurance programs and may result in copayments, coinsurance, or deductible obligations. I may withdraw consent at any time by scheduling an appointment and discussing with provider.

## Insurance Information

It is our intention to inform our patients of Medicare policy as it relates to their financial responsibilities for the sale or rental of Durable Medical Equipment [DME] supplied by Advanced Health Services, Inc. Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary; it is the beneficiary's responsibility to arrange for any required equipment service or repair. Medicare pays for most supplies needed for your equipment if the following has occurred:

- Face to face re-evaluation with your treatment provider 31-90 days after starting therapy
- Completion of the Epworth test
- Machine download reflecting use of the device for 70% over 30 consecutive nights for a minimum of 4 hours

Many commercial insurers use policies similar to Medicare; however, benefits and coverage requirements vary by plan for rental to purchase of equipment. For specific information on your plan, please contact your insurance company.

*Estimates of insurance coverage:*
*For out-of-pocket costs and a guarantee of benefits for any of our services, please contact your insurance directly. If you would like an estimate of coverage, feel free to reach out to the billing department.*

## HIPAA Form

Please see attached laminated copy for entire notice.

# 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.**

NOTICE OF PRIVACY PRACTICES

THE CENTER FOR SLEEP MEDICINE

Effective Date: 08/25/2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU MAY ACCESS THIS INFORMATION, AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION ("PHI"). PLEASE REVIEW IT CAREFULLY.

If you have any questions regarding this Notice or your privacy rights, please contact:

Denise Lee, Privacy Officer
The Center for Sleep Medicine
1924 Springbrook Square Drive
Naperville, Illinois 60564

OUR COMMITMENT TO YOUR PRIVACY

The Center for Sleep Medicine understands that information about your health is personal and confidential. We are committed to protecting the privacy and security of your Protected Health Information ("PHI") in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), applicable Centers for Medicare & Medicaid Services ("CMS") requirements, Illinois law, and other applicable federal and state regulations.

This Notice describes how we may use and disclose your PHI, your rights regarding that information, and our legal obligations to protect it.

This Notice applies to all PHI maintained by The Center for Sleep Medicine, whether that information is maintained in paper, electronic, verbal, photographic, audio, video, diagnostic, billing, monitoring, portal, telehealth, remote patient monitoring, prescription, sleep study, or other healthcare records.

PHI includes information that identifies you and relates to your:

- Past, present, or future physical health;
- Past, present, or future mental health;
- Healthcare services provided to you;
- Payment for healthcare services;
- Insurance coverage and eligibility;
- Diagnostic testing, sleep studies, PAP therapy, remote monitoring, prescriptions, and related healthcare services.

We are required by law to:

- Maintain the privacy and security of your PHI.
- Provide you with this Notice of Privacy Practices.
- Abide by the terms of the Notice currently in effect.
- Notify you if a breach of unsecured PHI occurs.
- Comply with applicable federal and state privacy laws.

We reserve the right to revise this Notice at any time. Any revised Notice will apply to all PHI maintained by our practice. Revised Notices will be available upon request and posted as required by law.

ELECTRONIC COMMUNICATIONS

To support efficient patient care, we may communicate with you using:

- Telephone
- Voicemail
- Text messaging (SMS)
- Patient portal messaging

- Electronic reminders
- Mail

These communications may relate to:

- Appointments
- Prescription refills
- Test results
- Treatment recommendations
- PAP compliance monitoring
- Remote patient monitoring
- Billing statements
- Insurance matters
- Care coordination

While we employ reasonable safeguards, electronic communications may involve risks. By providing contact information, you acknowledge and accept such risks to the extent permitted by law.

You may request alternative communication methods by contacting our Privacy Officer.

HEALTH INFORMATION EXCHANGE ("HIE")

The Center for Sleep Medicine may participate in one or more electronic Health Information Exchanges.

Health Information Exchanges allow participating healthcare providers and healthcare organizations to securely access and share medical information to facilitate:

- Treatment
- Payment
- Healthcare operations
- Care coordination
- Medication reconciliation
- Emergency healthcare services

Information exchanged may include:

- Demographic information
- Medical history
- Diagnoses
- Medications
- Allergies
- Sleep testing results
- PAP compliance information
- Laboratory data
- Billing information

We may disclose PHI to and receive PHI from authorized participants in such exchanges as permitted by applicable law. Patients may obtain additional information regarding any applicable HIE participation or opt-out rights where permitted by law

TELEHEALTH SERVICES

If you receive healthcare services through telehealth technologies, PHI may be collected, transmitted, stored, reviewed, and disclosed using secure electronic communication systems.

Information may include:

- Audio communications
- Video communications
- Images
- Medical records
- Diagnostic information
- Treatment recommendations

Telehealth services are subject to the same privacy protections that apply to in-person healthcare services.

REMOTE PATIENT MONITORING ("RPM")

The Center for Sleep Medicine may provide Remote Patient Monitoring services.

RPM may involve electronic collection, transmission, and review of healthcare information, including:

- PAP therapy compliance data
- Therapy usage information
- Device performance information
- Physiologic monitoring data
- Treatment adherence data

Information collected through RPM may be used for:

- Patient treatment
- Clinical decision-making
- Care management
- Quality improvement
- Medicare and commercial insurance billing
- Compliance documentation

RPM information becomes part of your designated medical record and is protected as PHI. Monitoring data may be shared with insurers, DME suppliers, and healthcare providers as necessary for treatment, coverage determination, compliance documentation, and payment.

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 Infom.ation.**

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.

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.

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.

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 a 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 the 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 Officer 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 Officer to request that these fundraising materials not be sent to you.

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.

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 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.

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.

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:

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.

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.

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.

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.

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.

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.

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.

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 (iv) responding to a medical emergency (not on the Practice premises) and it is likely that a crime has occurred.

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.

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 Revenue 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.

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.

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.

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.

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.

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.

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.**

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 Officer at the following address: 1924 Springbrook Square Drive Naperville, IL 60564, 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 Officer if you have any questions about access to your medical record.

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.

We are not required to agree to your request. 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 Officer.

You have the right to request to receive confidential communications from us at a location other than your primary address. We will try to accommodate reasonable requests. Please make this request in writing to our Privacy Officer.

You may have the right to have us amend your medical information. 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 Officer, 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.

You have the right to receive an accounting of disclosures we have made, if any, of your medical information. 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 Officer. 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.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. 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.

Right to be Notified of a Breach. 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.

Complaints: 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 Officer, in writing. We will not retaliate against you for filing a complaint.

The Center for Sleep Medicine
*An Employee-Owned Company*
The difference between going to bed, and going to sleep.™

# Contact Consent Form

Printed Name _____

Date of Birth _____

Email Address _____

Home # _____

Cell # _____

Medical Emergency Contact Name: _____ Relationship: _____

Medical Emergency Contact Number: _____

**PHI (Protected Health Information) Contact Authorization:**

Spouse/Partner: (name)_____ Yes ☐ No ☐

Child: (name) _____ Yes ☐ No ☐

Parent/Guardian: (name) _____ Yes ☐ No ☐

Other: (name) _____ Yes ☐ No ☐

****This authorization shall remain in effect until revoked in writing by patient. I understand that I may revoke this authorization at any time by submitting a written request to The Center for Sleep Medicine 1924 Springbrook Square Drive Naperville, IL 60564 Attn: Privacy Officer. Revocation will not affect disclosures already made based on this authorization****

# Medical Consent Form Signature Approval

Please **initial** to acknowledge receipt of these documents and understand that copies are available upon request:

_____ Cancellation/ No Show Policy v2.0

_____ e Prescribing Consent Form v2.0

_____ Financial Policy v2.0

_____ Authorization of Benefits v2.0

_____ Insurance Information v2.0

_____ HIPAA Form v2.0

Signature _____ Date _____