HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a medical equipment company that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary Information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a sleep study may require that your relevant protected health information be disclosed to the health plan to obtain approval for the sleep study.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a signin 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 protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or

administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health 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 of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice

from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our office manager.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

GENERAL CONSENT TO CARE AND TREATMENT AGREEMENT TO THE PATIENT/GUARDIAN:

I have the right to be informed about my condition and the recommended diagnostic or therapeutic procedures to be used so that I may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

I consent to allow the providers of the Healthy Sleep MD to perform necessary medical examinations and tests to diagnose and treat my health conditions.

This consent provides my provider with my permission to perform reasonable and necessary medical examinations, testing and treatment.

By signing below, I am indicating that I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended.

I consent to treatment at this office or any other satellite office under common ownership.

The consent will remain fully effective until it is revoked in writing.

I have the right at any time to discontinue services. I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me.

If I have any concerns regarding any test or treatment recommend by my health care provider, I am encouraged to ask questions.

I voluntarily request any health care provider at Healthy Sleep MD as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand that Healthy Sleep MD is not responsible if I decline or do not complete their recommended testing or treatment for my condition(s).

I understand healthcare students and trainees may be involved in my care.

I have the right to have a chaperone present when I am with my provider. A chaperone is required for any sensitive examination unless I decline a chaperone in writing. If I am consenting on behalf of a child under 11 years of age, I may serve as the chaperone.

I understand that Healthy Sleep MD is not responsible for any of my clothing, valuables, or other personal belongings left behind. I understand that I hereby release Healthy Sleep MD from any liability for any and all personal possessions which I choose to keep with me during my office visit or any sleep studies.

RELEASE OF INFORMATION I hereby authorize Healthy Sleep MD, or its designee, to release information, in written form, by phone, or facsimile machine, contained in the patient's medical records. I specifically authorize the release of drug and alcohol abuse records in accordance with the Federal Regulations and/or communications made by me to a social worker or psychologist and/or records pertaining to communicable diseases.

I hereby assign, transfer, and set over unto Healthy Sleep MD as its interest may appear all benefits now due or becoming due to me by virtue of the present office treatment.

AGREEMENT TO PAY FOR SERVICES I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible to pay for all services to be rendered to the patient whether signing as agent or as patient.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Insurance and Payment Policy

You must provide a valid driver's license or state ID and medical insurance card at every visit.

It is the patient's responsibility to know the coverage provided in their contract with their insurance agency and the frequent changes that occur. Every contract varies; we therefore recommend reviewing your contract or contacting your insurance company to determine your co-pay, deductible, need for referral, covered procedures, covered equipment and if Healthy Sleep MD is in network.
Referrals are requested before the appointment can be scheduled in order to prevent complications with insurance coverage.

Please inform us of any changes in coverage prior to services rendered. If insurance is denied due to a change or termination in the policy, the service will become due and payable by you.

All pre-determined copays and remaining balances must be paid at the time of check in. If the payment is not made at the time of the appointment, the appointment will be canceled.

If your insurance has a deductible, you may be required to pay 50% of the bill amount; we will determine this on the day of the visit. Please note that your insurance contract requires payment of these fees and our insurance contract requires collecting payment per plan agreement. We cannot release or modify financial obligations as set by your insurance provider agreement.

If a patient is choosing to self-pay for their appointment whether due to lack of insurance or not being in network, full payment is due at the time of the visit. Failure to provide payment before the appointment may result in cancellation of the appointment.

Payments accepted include cash, check and credit card (Visa & Mastercard). If electing to use credit card, you may be responsible for a processing fee of up to 3%. If you are unable to provide payment on the date of your scheduled appointment, your appointment will be rescheduled and you may incur a rescheduling fee. Returned checks are subject to a $35 returned check fee, and you have 7 days to contact the office to arrange another method of payment.

If payment is not received within 30 days from the statement date, we will run the credit card on file for the full amount owed. If your payment is declined, we will contact you to correct the payment method.

If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed.

The unpaid balance will be subject to a finance charge of 1.5% or $35 per statement, whichever is greater. If payment is not received by the third billing cycle, Healthy Sleep MD may pursue litigation to collect balances and the patient/guarantor will be responsible for all filing fees, attorney fees and/or the cost of collections in the event of default. Further delinquency will be subject to collections with an additional 35% handling fee.

If you have any concerns, please contact our billing department.

Assignment and Release: I authorize payment to be made directly to Healthy Sleep MD by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy: Healthy Sleep MD is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number in a secure, compliant location in your electronic medical record.

For security reasons, only the last four digits will be visible to our staff. Credit cards on file will be used to pay the predetermined copay on the day of your visit, as well as account balances after your insurance processes your claim.

I give Healthy Sleep MD permission to charge my credit card on file for any patient balance due on my account. If I have insurance coverage, my card will be charged my pre-determined copay on the day of my appointment. After my insurance pays their portion, the remaining balance will be added to my account balance and charged to the credit card on file at the end of the next billing cycle.

Medical Records Request Policy: The patient/guarantor reserves the right to obtain medical records. This will require a $25 fee to be paid before the request can be processed. The request will be processed within 10 business days from the date of payment. Payments accepted are cash and credit card, the latter of which is subject to up to a 3% processing fee.

Form Completion Policy: If you need a form completed, please bring to your office visit. The office charges a $30 fee to complete any forms requested >24 hours from the time of any clinic appointment. The form will be processed within 72 hours after payment is received.

Cancellation and No-Show Policy
In order to provide high quality and timely care to our patients, there will be a fee for cancellations or rescheduling of appointments. This will allow us to efficiently utilize appointments for patients who need rapid access to medical care.

Should you need to reschedule a clinic appointment, please call our office **no less than 48 hours from the scheduled appointment time.**

If a clinic appointment is missed, cancelled or rescheduled < 48 hours of the scheduled time, the patient is responsible for a $50 fee that will be charged onto the credit card on file. The appointment will not be rescheduled until the fee is paid.

The process to authorize and schedule a sleep study is very complex. If any type of **sleep study appointment (including any in lab testing and at home testing)** is missed, cancelled or rescheduled < 72 hours of the scheduled appointment time, the patient is responsible for a $250 fee for each occurrence. This will be charged on the credit card on file. The study will not be rescheduled until the fee is paid.

Financial Responsibility: I have read and understand the payment and policies of Healthy Sleep MD and its contractual obligation to my chosen insurance provider. I understand that I am responsible to pay for the services rendered at the time of service. If I do not pay for services rendered, I understand Healthy Sleep MD may pursue collections litigation to collect balances and that I will be responsible for all filing fees, attorney fees and/or the cost of collections in the event of default.

_____ _____
Signature of patient or representative Date

_____ _____
Printed name of patient or representative Relationship to patient

Thank you for choosing Healthy Sleep MD, PLLC your health care provider. We are committed to the success of your treatment and care. Payment for services provided is a part of the physician-patient relationship with your doctor. Per the financial policy of the practice, patients and guarantors are responsible for making the necessary payments toward the services they receive. With the changing environment in health care, more responsibility for payment is being placed on the patient in the form of copays, high deductibles and out-of-pocket costs. *Revised 5/2025*