SLEEP HEALTH MD

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

PATIENT MUST BE PRESENT AT EVERY VISIT !

PATIENTS INFORMATION:

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

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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

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

SECONDARY INSURANCE NAME _____ ID NUMBER _____ GROUP NUMBER _____

PARENTS INFORMATION:

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

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

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

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

INSURED SIGNATURE / GUARDIAN _____ DATE _____

PEDIATRIC PATIENT QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS BELOW:

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

   _____
   _____
   _____
   _____

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

   _____
   _____
   _____
   _____

3. Does your child snore?
   ☐YES ☐NO

4. Describe the snoring:
   ☐Light
   ☐Occasional
   ☐Constant
   ☐Heavy
   ☐Other

5. Do you ever observe your child:
   ☐Stop Breathing
   ☐Gasp
   ☐Choke
   ☐None

6. How many times does your child wake up after falling asleep?

   _____
   _____

7. Please check the reasons why your child wakes up after falling asleep?
   ☐Need to urinate
   ☐Shortness of breath
   ☐Screaming
   ☐Anxiety
   ☐Nightmares
   ☐Headaches
   ☐Dry Mouth
   ☐Nasal congestion

8. Does your child have any of the following:
   ☐Bedwetting
   ☐Teeth grinding
   ☐Sleep walking
   ☐Sleep talking
   ☐Restless Sleep
   ☐Trouble getting up in the morning.
   ☐Mouth breathing
   ☐Sees frightening images before falling asleep or after awakening
   ☐Does your child complain about not being able to move after they wake up.
   ☐Feels weak or loses control of muscles with strong emotion (such as laughter)

9. Does your child nap?
   ☐YES ☐NO
   Number of naps per day_____
   Number of naps per week_____

10. How is your child's school performance?
    - ☐ Above Average
    - ☐ Average
    - ☐ Below Average

11. Does your child experience:
    Check all that apply:
    - ☐ Daytime sleepiness or fatigue
    - ☐ Falling asleep in school
    - ☐ Falling asleep with reading or tv
    - ☐ Difficulty paying attention at home or school.
    - ☐ Depression
    - ☐ Hyperactivity at home/school
    - ☐ Aggressive behavior

MEDICAL HISTORY

12. Check all that apply:
    - ☐ Frequent nasal congestion or trouble breathing through the nose
    - ☐ Sinus problems
    - ☐ Chronic Bronchitis or cough
    - ☐ Allergies
    - ☐ Frequent colds, flu, or sore throats
    - ☐ Poor or delayed growth
    - ☐ Excessive Weight
    - ☐ Hearing problems
    - ☐ Speech problems
    - ☐ Vision problems
    - ☐ Headaches
    - ☐ Pain
    - ☐ Seizures or epilepsy

ALLERGIES: _____

Height_____**Weight**_____

Any other medical problems? Please list:

_____

_____

_____

13. Does your child drink caffeinated beverages (Coke, Pepsi, Mountain Dew, etc.)?
    ☐ YES ☐ NO

    If the answer is yes, how much per day?

    _____

    _____

14. Please list any previous hospitalization or surgeries (including tonsils and adenoids)

    _____

    _____

    _____

    _____

    _____

15. Please list all medications:

    _____

    _____

    _____

    _____

    PHARMACY:_____

    _____

DOCTORS NOTES:

_____

_____

_____

_____

_____

PARENT/GUARDIAN SIGNATURE DATE

_____

PHYSICIAN SIGNATURE DATE

Sleep Health MD Notice of Privacy Practices

Effective date, January 1, 2018

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

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

I. OUR PLEDGE:

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

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

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

III. WHAT DOES "CLINICAL OPERATIONS" INCLUDE?

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

IV. HOW IS MEDICAL INFORMATION USED?

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

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

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

We will use medical information to plan treatment.

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

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

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

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

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

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

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

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

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

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

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

VIII. YOUR PRIVACY RIGHTS

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

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

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

3. You have the right to request to receive private communications in another way or at other locations.
We will agree to reasonable requests. To carry out the request, we may also ask you for another address or another way to contact you, for example, mailing to a post office box.

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

5. You have the right to receive a record of when your health information has been disclosed by Sleep Health MD.
You have the right to request a record (accounting) of when Sleep Health MD has disclosed your PHI except for uses and disclosures for treatment, payment, and clinical operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.
Requests for records about Sleep Health MD's disclosures of your PHI may not be made for time periods of more than six (6) years or it could be an earlier time period depending upon what the law requires.

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

CHANGES TO THIS NOTICE

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

GENETIC INFORMAITON DISCRIMINATION ACT (GINA)

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

BUSINESS ASSOCIATES

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

WHAT IF I HAVE A QUESTION OR COMPLAINT?

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

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

Sleep HEALTH MD

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

I understand that as part of my healthcare, this organization Sirsh Nakka, MD Inc (Sleep Health MD) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as a:

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

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Notice of Information Practices

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. If you have any questionsregarding billing please contact our billing compliance officer. **Initial here _____**

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance to issue payment check(s) directly to Sirish Nakka MD, Inc. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for any amount not covered by insurance.

Initial here _____

Consent to Obtain Medication History

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

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

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