Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: ____________________ @ _______ pm

Location: 13920 North Western Avenue; Edmond, OK 73013

Web Site: www.sleepsolutionsllc.net

Our sleep lab has been designed with your comfort in mind. The atmosphere is warm and inviting, very similar to a nice, quality hotel room. We offer the conveniences of a flat screen television (w/DVD), and reading materials. Our primary goal is to create an environment that will assist in getting a "normal" night's sleep.

Please note that a technician will not arrive until 8:00 PM.

* Reminder: No nap or caffeine after 12 pm the day of your study. Please eat dinner before you come.
*** IMPORTANT: You must cancel or reschedule 24 hours before your set appointment or you will be charged a technician fee of $250.00. To receive a refund of the fee, all appointments must be rescheduled within 72 hours of the original scheduled appointment and you must attend the newly scheduled appointment.**

Please ring the doorbell for admittance into the lab.

Things to bring with you:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something loose fitting and comfortable to sleep in, as well as, a robe and slippers.
3. All medications that you are currently taking - (please have them written down prior to arrival)
4. Your insurance card and two forms of identification including a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Your hair **must** be clean and free of gels and hair spray materials.
3. We have pillows; however, please feel free to bring your own to add to your comfort.
4. Bring an overnight bag with the items you would normally use for an overnight stay.
5. Smoking materials, tobacco, and firearms are prohibited in our facility.

Your estimated cost will be ___________ Please note that the amount you have been quoted to pay is an estimation of benefits based on the information provided to us by your insurance company. This information cannot be relied upon as a final agreement of financial responsibility. Some charges may differ depending on your insurance plan and the processing of charges. If you have any questions please contact your insurance company or our office for further clarification.

You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above. If you have met more of your deductible please contact our office with this so we can call your insurance company. This could considerably change your cost.

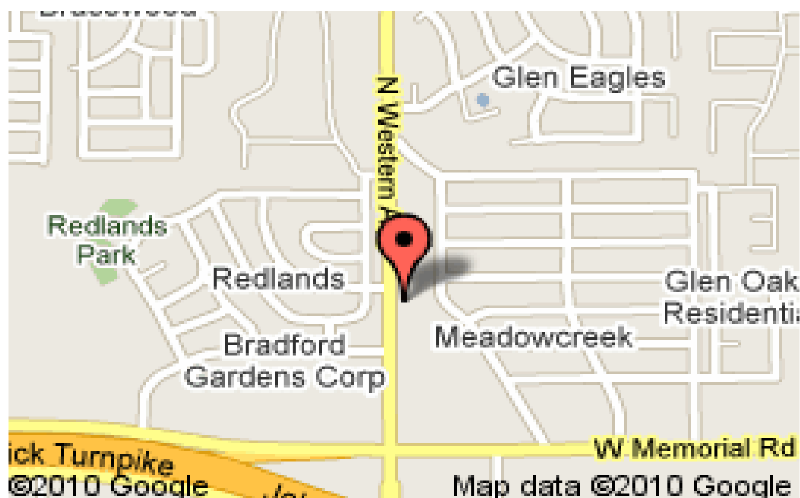
We accept VISA, MasterCard, Discover, and checks. **NO CASH PLEASE.**

If you have any questions about this sleep study or any information contained in this letter, please contact us prior to your appointment. Our patient care coordinator will be happy to answer any questions you may have – (405) 949-0060 – M-F 8:30-5:00.

After Hours, please call 405-600-1241.

13920 North Western Avenue,
Edmond, OK 73013

We are located on Western Ave, approximately ½ mile north of Memorial Road. Our sleep lab is located on the East side of the road across from the Redlands housing addition.



For assistance after hours, please contact a technician at 405-600-1241.

SLEEP STUDY MEDICAL HISTORY

Patient Name: ____

Height: ________ Weight: _______ Age: _________

Symptoms of Sleep Disturbances: (check those that apply)

- ☐ Witnessed apnea
- ☐ Post UPP
- ☐ Snoring
- ☐ Restless legs
- ☐ Nocturnal choking
- ☐ Leg/body jerks
- ☐ Fitful sleep
- ☐ REM Behavior
- ☐ Depression
- ☐ Shortness of breath
- ☐ Nightmares
- ☐ Obesity
- ☐ Bedwetting
- ☐ Nasal obstruction
- ☐ Sleep terrors
- ☐ GI reflux/heartburn
- ☐ Sleep attacks
- ☐ Nightmares
- ☐ Sleep-Walking
- ☐ Asthma
- ☐ Elongated palate
- ☐ Excessive sleepiness
- ☐ p.m. alcohol
- ☐ Chronic Pain
- ☐ Periodic leg movement
- ☐ Frequent awakenings
- ☐ Violent activity during sleep
- ☐ chronic fatigue
- ☐ Narcolepsy
- ☐ Cataplexy
- ☐ Insomnia
- ☐ Claustrophobia

Pertinent Medical History: (check those that apply)

- ☐ High Blood pressure
- ☐ COPD/Emphysema
- ☐ s/p stroke
- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Kidney failure
- ☐ Cerebral Palsy
- ☐ Head injury
- ☐ Head injury
- ☐ Neuromuscular disease
- ☐ Seizures
- ☐ Premature birth
- ☐ Thyroid disease
- ☐ Broken nose
- ☐ Oxygen: LPM____
- ☐ History of Motor Vehicle Accident
- ☐ Heart attack
- ☐ Memory loss
- ☐ Neuromuscular Disease
- ☐ Parkinson's Disease
- ☐ Mood disorder
- ☐ Fibromyalgia
- ☐ Other:__________________

Surgeries: (check those that apply)

☐tonsils ☐adenoids ☐UPPP ☐deviated septum ☐nasal polyp ☐laser
☐tracheotomy ☐upper or lower ☐jaw reconstruction

Previous Sleep Study:

☐No ☐Yes When and where:____

(If previous sleep study, please include a copy of this report.)

Current Treatment of Sleep Apnea:

☐CPAP Pressure___________ ☐ Bi-Level Pressure___________ ☐Oxygen Liters__________

Medications:____

____

____

*Revised 7/12/2011

SLEEP QUESTIONNAIRE

Name: ____________________________________ Date of Study: ______________

Patient ID: ____________________

AGE: ________ SEX: _______ Date:__________

REFERRING PHYSICIAN: ____

HT: ______ WT: ______ Neck Size: ______

PLEASE GIVE THE COMPLETED QUESTIONNAIRE TO THE TECHNICIAN AT THE TIME OF YOUR SLEEP STUDY.

MY PRIMARY SLEEP COMPLAINT IS: ______________________________________

HOW LONG HAVE YOU HAD THIS PROBLEM? _______________________________

HAVE YOU EVER SEEN A PHYSICIAN FOR THIS PROBLEM? ___________________

HAVE YOU EVER HAD A SLEEP STUDY? ___________________________________

(IF YES, WHEN AND WHERE) ____

DO YOU HAVE ANY OTHER SLEEP PROBLEMS? _____________________________

(IF YES, PLEASE DESCRIBE) ____

DO ANY OF YOUR FAMILY MEMBERS HAVE A SLEEP DISORDER? (IF YES, DESCRIBE)
____

DO YOU USE OXYGEN AT HOME? NO ___ YES ___ 24 HR/DAY ___ NIGHT ONLY ___

MEDICATION NAME	DOSAGE	REASON

****USE THE OTHER SIDE OF THIS PAGE TO LIST ADDITIONAL MEDICATIONS.

LIST YOU INTAKE PER DAY OF THE FOLLOWING:

ITEM	DAILY INTAKE	ITEM	DAILY INTAKE	ITEM	DAILY INTAKE
COFFEE		BEER		CIGARETTES	
CAFFIENE SODA		WINE		CIGARS/PIPE	
TEA		LIQUOR		SNUFF	

WHAT TIME DO YOU GO TO SLEEP? __________WHAT TIME DO YOU WAKE UP?________

HOW LONG DOES IT USUALLY TAKE YOU TO FALL ASLEEP?___________

DO YOU AWAKEN OFTEN DURING THE NIGHT? ______________________

(IF YES, WHY?) ____

DO YOU NAP DURING THE DAY? ________________________________

(IF YES, DO YOU FEEL REFRESHED UPON AWAKENING?) ____________

DO YOU WORK DIFFERENT SHIFTS? ______________________________

(IF YES, WHAT SHIFT(S) DO YOU WORK?) ________________________

Name: ______________________________________ Date of Study: _______________

Patient ID: _____________________

Please answer the following questions using this scale: (Consult bed partner)
0=never 1=rarely 2=sometime 3=often 4=frequently 5=always

EXCESSIVE DAYTIME SLEEPINESS:

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY.

0 1 2 3 4 5 I SOMETIMES FALL ASLEEP WHEN I DON'T WANT TO.

0 1 2 3 4 5 I FALL ASLEEP WHEN I READ THE NEWSPAPER.

0 1 2 3 4 5 I FALL ASLEEP WHILE WATCHING TV.

0 1 2 3 4 5 I FALL ASLEEP AT WORK.

0 1 2 3 4 5 I FALL ASLEEP AT MEETINGS.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE DRIVING.

0 1 2 3 4 5 I GET SLEEPY WHILE DRIVING.

0 1 2 3 4 5 I HAVE PROBLEMS WITH MY PERFORMANCE AT WORK BECAUSE OF FATIGUE AND TIREDNESS.

0 1 2 3 4 5 I DON'T FEEL REFRESHED WHEN I AWAKEN.

0 1 2 3 4 5 I HAVE TO TAKE NAPS DURING THE DAY.

0 1 2 3 4 5 I GET SLEEPY WHEN I AM INACTIVE.

0 1 2 3 4 5 I HAVE TO PUSH MYSELF TO GET THINGS DONE.

0 1 2 3 4 5 I HAD TROUBLE STAYING AWAKE DURING THE DAY AS A CHILD.

SLEEP APNEA:

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I SNORE.

0 1 2 3 4 5 OTHERS CAN'T SLEEP IN THE SAME ROOM BECAUSE I SNORE.

0 1 2 3 4 5 I HAVE BEEN TOLD I STOP BREATHING WHILE ASLEEP.

0 1 2 3 4 5 I AWAKEN WITH HEADACHES.

0 1 2 3 4 5 I AM OVERWEIGHT OR AM GAINING WEIGHT.

0 1 2 3 4 5 I PERSPIRE AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I'M A RESTLESS SLEEPER.

0 1 2 3 4 5 I HAVE AWAKENED DURING THE NIGHT CHOKING.

0 1 2 3 4 5 I FEEL SLEEPY DURING THE DAY EVEN THOUGH I SLEPT ALL NIGHT.

0 1 2 3 4 5 I HAVE ASTHMA ATTACKS DURING SLEEP.

Name: ________________________________ Date of Study: ______________

Patient ID: _________________________

RESTLESS LEG SYNDROME OR NOCTURNAL MYOCLONUS:

0 1 2 3 4 5 I HAVE MUSCLE TENSION IN MY LEGS EVEN WHEN I'M RELAXED.

0 1 2 3 4 5 I HAVE BEEN TOLD PARTS OF MY BODY "JERK" AT NIGHT.

0 1 2 3 4 5 I HAVE BEEN TOLD I KICK DURING THE NIGHT.

0 1 2 3 4 5 I HAVE ACHING OR "CRAWLING" SENSATIONS IN MY LEGS.

0 1 2 3 4 5 I EXPERIENCE LEG PAIN DURING THE NIGHT.

0 1 2 3 4 5 SOMETIMES I CAN'T KEEP MY LEGS STILL AT NIGHT.

INSOMNIA:

0 1 2 3 4 5 I HAVE TROUBLE GETTING TO SLEEP AT NIGHT.

0 1 2 3 4 5 I HAVE TROUBLE STAYING ASLEEP AT NIGHT.

0 1 2 3 4 5 I AWAKEN IN THE MORNING LONG BEFORE I WANT TO.

0 1 2 3 4 5 I WORRY I WILL BE UNABLE TO SLEEP.

0 1 2 3 4 5 I AWAKEN WITH FEELINGS OF ANXIETY OR FEAR.

SLEEP BEHAVIOR:

0 1 2 3 4 5 I HAVE BEEN TOLD I WALK IN MY SLEEP.

0 1 2 3 4 5 I HAVE BEEN TOLD I TALK IN MY SLEEP.

0 1 2 3 4 5 AS AN ADULT, I HAVE WET THE BED.

0 1 2 3 4 5 WHEN I LAUGH OR GET ANGRY, I FEEL LIKE I'M GOING LIMP.

0 1 2 3 4 5 I HAVE FALLEN ASLEEP WHILE LAUGHING OR CRYING.

0 1 2 3 4 5 I HAVE VIVID DREAM-LIKE SCENES UPON FALLING ASLEEP.

0 1 2 3 4 5 I FEEL LIKE I WALK AROUND IN A DAZE.

0 1 2 3 4 5 SOMETIME I CAN'T TELL DREAMS FROM REALITY.

0 1 2 3 4 5 I AWAKEN DURING THE NIGHT WITH HEARTBURN.

0 1 2 3 4 5 I HAVE BEEN TOLD THAT I ACT OUT MY DREAMS.

0 1 2 3 4 5 I HAVE NOW OR IN THE PAST HAD SEIZURES IN MY SLEEP.
WHEN _______

LIST ANY PAST/PRESENT MEDICAL OR PSYCHAITRIC PROBLEMS. LIST ANY OTHER CONCERNS YOU HAVE ABOUT YOUR SLEEP.

____

____

____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Patient Information:

Patient Name: ____ DOB: ________Age: ______________

Address: _______________________________ City: ____________________ Zip: ______________

Home Phone: _________________ Work:______________________ Cell: ______________________

Ht______ LBS__________ Referring Physician_________________________________

Primary Care Physician_______________________ Phone Number ________________

SS#: ___________________________________ Gender: ☐ Male ☐ Female

Marital Status ☐S ☐M ☐D ☐W

Email: ____

Insurance Information: **Please provide our office with a copy of your insurance card.**

Primary Insurance Carrier:__________________________ Phone: __________________________

ID #: _______________________________ Policy Group #: ________________________________

Policy Holder: _________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Secondary Insurance Carrier:________________________ Phone: __________________________

ID #: _______________________________ Policy Group #: ________________________________

Policy Holder: _________________________________ Relationship to Patient: __________________

Policy Holder's Date of Birth: _____________________ Policy Holder's SS#: ____________________

Employment Information:

Employer_______________________________ Work Ph#: _______________________

If the patient is a minor, please list guardian information:

Guardian: _______________________________ Phone #: ________________________

Third Party Billing:

Is your injury work related?	☐**Yes**	☐**No**
Is this injury due to an accident?	☐**Yes**	☐**No**
If your injury is MVA related, have you obtained an accident report?	☐**Yes**	☐**No**

Injury date or Date of Occurrence:_____________________________.

Emergency Contact:

Name: ____ Relationship: ____________________

Phone: ____________________________________

Epworth Sleepiness Scale

Patient: ____ Date: ____________

The instrument

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

Situation	Chance of dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

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Assignment of Benefits:

As a courtesy to the patients and their families, Sleep Solutions does submit a claim to many third party payers. I request that payment of authorized Medicare or private benefits be made to Sleep Solutions for any covered services furnished to me by Sleep Solutions. If my insurance carrier pays me directly, I agree to forward all funds to Sleep Solutions within 10 working days. I agree that I am responsible for paying all non-covered or unpaid amounts unless otherwise provided by law, regulation or Sleep Solutions contractual relationships. I agree to be responsible for the full amount of the charges from the date of delivery which my third party payer does not pay for in a timely manner, or if I fail to provide within (10) days the information necessary to submit the claim for payment.

Informed Consent:

I authorize Sleep Solutions, LLC**,** to perform the sleep study as prescribed by my physician.

Disclosure of Information:

I understand that my medical records and billing information are made and retained by Sleep Solutions and are accessible to Sleep Solutions personnel, who may use and disclose medical information for Sleep Solutions operations and functions and to any other health care personnel, involved in my continuum of care for this product.

Release of Records:

I authorize Sleep Solutions to release to any governmental healthcare program and its agents, or to any private insurance company or its agents any information needed to determine my benefits or the benefits payable for Sleep Solutions.

I hereby authorize my ordering physician to release all medical records pertaining to my healthcare information to Sleep Solutions. I understand further, the information, authorized for release may include records which may have the presence of a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also knows as Acquired Immune Deficiency Syndrome (AIDS).

Acknowledgment of Notice of Privacy Practices:

A complete description of how my medical information will be used and disclosed by Sleep Solutions has been given to me in Sleep Solutions HIPAA compliant NOTICE OF PRIVACY PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this Consent Form. If I have questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Privacy Practices.

Please list any names of persons with whom Sleep solutions can discuss your health care information.

Name: ____________________________ Relationship: _____________________________

Name: ____________________________ Relationship: _____________________________

Name: ____________________________ Relationship: _____________________________

☐ I give Sleep Solutions permission to contact me via e-mail with any information regarding my confidential medical records. **Email:** ____

☐ I would like to have a copy of the final study mailed to my address.

____ ___________________________________

Patient (or Parent/Guardian or Representative) Date

Relationship to Patient | Witness

NOTICE OF PRIVACY PRACTICES

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

Understanding your Health Record/Information:

Each time you visit Sleep Solutions, LLC. A record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- ■Basis for planning your care and treatment
- ■Means of communication among the many health professionals who contribute to your care
- ■Legal document describing the care you received
- ■Means by which you or a third party payer can verify that services billed were actually provided
- ■A tool in education health professionals
- ■A source of data for medical research
- ■A source of information for public health officials who oversee the delivery of health care in the United States
- ■A source of data for Sleep Solutions planning and marketing
- ■A tool with which we can assess and continually work to improve the care we render and the Outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

<u>Our Responsibilities</u>

Sleep Solutions, LLC is required to:

- ■Maintain the privacy of your health information
- ■Provide you with a notice as to our legal duties and privacy practices with respect to information We collect and maintain about you.
- ■Abide by the terms of this notice
- ■Notify you if we are unable to agree to a requested restriction
- ■Accommodate reasonable requests you may have to communicate health information by Alternative means at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain.

We will not disclose your health information without your authorization, except as described in this notice.

<u>How We Will Use or Disclose Your Health Information</u>

(1) Treatment. We will use your health information for treatment. For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician and/or technician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, we will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged.
(2) Payment. We will use your health information for payment. For example, a bill may be sent to you or a third-party payer, including Medicare or Medicaid. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

(3) Health care operations. We will use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This

information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

(4) Business associates. There are some services in our organization through contacts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

(5) Directory. Unless you notify us that you object, we may use your name for directory purposes. This information may be provided to people who ask for you by name.

(6) Notification. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care. If we are unable to reach your family member or personal representative, we may leave a message for them at the phone number that they have provided us, e.g., on an answering machine, to return our call without disclosing your identity in doing so.

(7) Communication with family. Health professionals, using their best judgment, may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

(8) Research. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

(9) Funeral Directors. We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.

(10) Organ procurement organizations. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

(11) Marketing. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

(12) Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

(13) Workers compensation. We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

(14) Public Health. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

(15) Correctional Institution. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, information necessary for your health and the health and safety of other individuals.

(16) Law Enforcement. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

(17) Reports. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Your Health Information Rights

Although your health record is the physical property of Sleep Solutions, LLC, the information in your health record belongs to you. You have the following rights:

You may request that we not use or disclose your health information for a particular reason related to treatment, payment, Sleep Solutions operations, a particular family member, other relative or close personal friend. We ask that such requests be made in writing on a form provided by Sleep Solutions, LLC. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it. For more information about this right, see 45 Code of Federal Regulations (C.F.R.) 164.522(a).

If you are dissatisfied with the manner in which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at an alternative location. Such a request must be made in writing, and submitted to Sleep Solutions, 13920 North Western, and Edmond, OK 73013.
We will attempt to accommodate all reasonable requests. For more information about this right, see (C.F.R.) 164.522(b).

You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If you request copies, we will charge you a reasonable fee. For more information about this right, see C.F.R. 164.524.

If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by Sleep Solutions, LLC., to make such requests. For a request form, please contact the staff on duty. For more information about this right, see 45 C.F.R. 164.526.

You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years.) We ask that such requests be made in writing on a form provided by Sleep Solutions, LLC. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health operations; disclosures made to you or your legal representative, or any other individual involved in your care; disclosures to correctional institutions or law enforcement officials and disclosures for national security purposes. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee. For more information about this right, see 45 C.F.R. 164.528.

You have the right to obtain a paper copy of our Notice of Information Practices upon request.

You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

For more information or to report a problem

If you have questions and would like additional information, you may contact Sleep Solutions Compliance Officer at 409 E California Ave, Oklahoma City, OK 73104 or 405-600-1261.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing on a form provided by Sleep Solutions, LLC. You may also file a complaint with the Secretary of the Federal Department of Health and Human Services. There will be no retaliation for filing a complaint.