## Scheduled Appointment Information

Date and Time: _____@ _____ pm
**Location: 7702 E 91st St. Suite 200, Tulsa, OK 74133**

**PLEASE DO NOT ARRIVE EARLY FOR YOUR SLEEP STUDY. THE TECHNICIAN WILL NOT BE AVAILABLE UNTIL 7:00 PM. PLEASE CONTACT OUR OFFICE IF YOU PLAN TO BRING A GUEST. WE HAVE LIMITED ROOMS AND WILL NEED TO MAKE SURE THERE IS AN EXTRA BED FOR YOUR GUEST.**

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. Our primary goal is to create an environment that will assist in getting a "normal" night's sleep.

For convenience and comfort, we do provide night lights, fans, cable T.V., and drinks are available. Feel free to bring a book or magazine to read before lights out. However, we do ask you don't bring any kind of "work" with you, such as a laptop, etc. We also have a shower available for use in the morning.

* Reminder: No nap or caffeine after 4 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.**

**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 a form 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, alcohol, and firearms are prohibited in our facility.

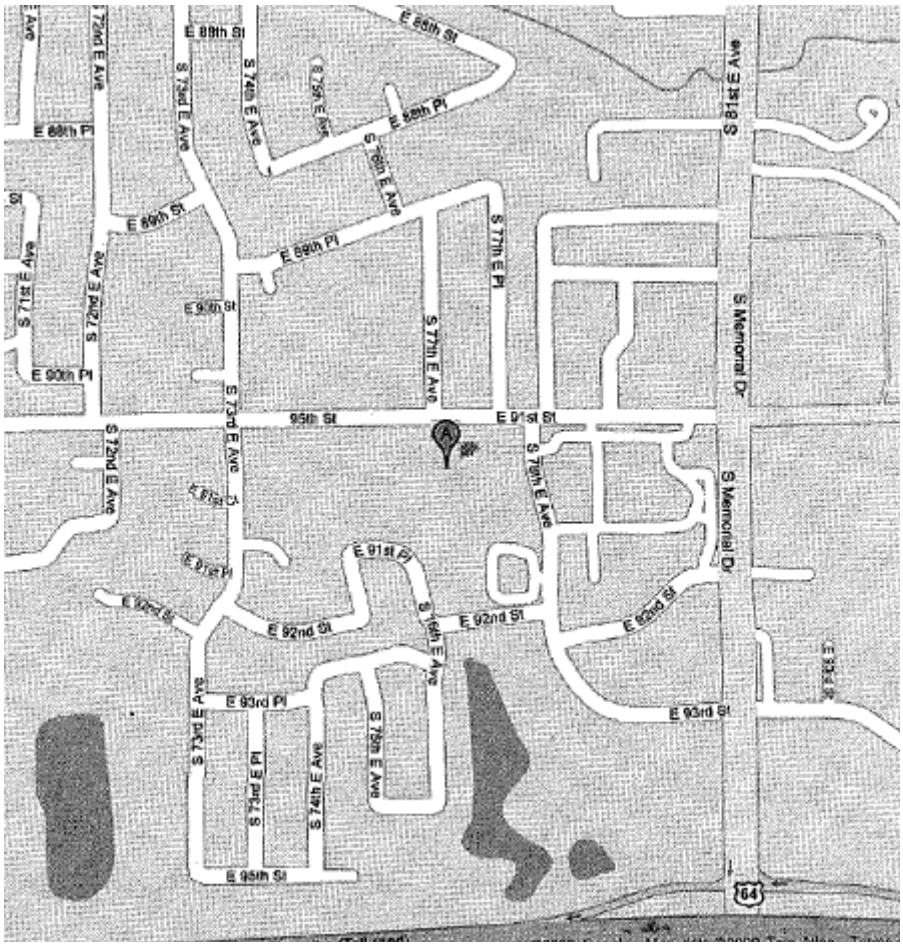
**Insurance and Financial Information:**

Your estimated cost will be _____Please note 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.

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 so we can call your insurance company. This could considerably change your cost.

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

Our website is www.sleepsolutionsllc.net. There is valuable information regarding sleep disorders and treatments on our website. You will also find online surveys, FAQs section, and even our video showing you the process!
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.
Monday - Friday 8:30 - 5:00 (918) 398-6378




**Sleep Solutions is located on 91st Street approximately 2 blocks West of Memorial. We are between 73rd and 78th E Ave. Our office is located in the South Springs Plaza, which is on the south side of 91st Street. Once you turn into the complex, you will need to go straight back. Sleep Solutions is the last office on the left.**

**If you require assistance locating this location after 5:00 pm, call: 918-398-6378.**
**7702 E 91st St. Suite 200, Tulsa, OK 74133**

# Information on Sleep Disorders

**Are you getting a good night's sleep? Sleep disorders cause more than just sleepiness** – a lack of restorative rest can cause accidents on the job and on the road; affect your relationships, health, and mental capability; and make you feel generally "disconnected" to the world around you. .

## Sleep disorder symptoms

Getting a good night's sleep is essential for feeling refreshed and alert during the day. Sleep disorders left untreated can even be hazardous to your health. Luckily, through proper testing, diagnosis and care, sleep disorders can be managed and overcome.

Particular behaviors during normal daytime activities are telltale signs of sleep deprivation. If you are experiencing one or more of the following symptoms during the day, you may not be getting enough restful sleep at night, and you may even have a sleep disorder.

### Do you . . .

- feel irritable or sleepy during the day?
- have difficulty staying awake when sitting still, such as when watching television or reading?
- fall asleep sometimes while driving?
- have difficulty paying attention or concentrating at work, school, or home?
- perform below your potential in work, school, or sports?
- often get told by others that you look tired?
- have difficulty with your memory?
- react slowly?
- have emotional outbursts?
- feel like taking a nap almost every day?
- require caffeinated beverages to keep yourself going?

## Common types of sleep disorders

In order to get a proper diagnosis, it's important to understand the symptoms and causes of the most common forms of sleep problems - **Sleep Apnea, Insomnia, RLS, and Narcolepsy.**

### Sleep Apnea Sleep Disorder

Sleep apnea is a common disorder that can be very serious, and even life-threatening. In sleep apnea, your breathing stops or gets very shallow while you are sleeping. Each pause in breathing typically lasts 10 to 20 seconds or more. These pauses can occur 20 to 30 times or more an hour.

The most common type of sleep apnea is **obstructive sleep apnea.** During sleep, enough air cannot flow into your lungs through your mouth and nose, even though you try to breathe. When this happens, the amount of oxygen in your blood may drop. Normal breaths then start again with a loud snort or choking sound.

Symptoms can be quite scary - frequent waking episodes at night, usually accompanied by a feeling of "choking" or gasping for air. Significant others or roommates of those with sleep apnea often report hearing gasping, gagging, or choking sounds from their partners. The severity of this disorder makes treatment essential. Treatment may include behavioral changes, a CPAP/BiPap machine, and in some cases, surgery.

## Insomnia

Insomnia is a significant lack of high-quality sleep. It can be short-term or chronic. Insomnia may be caused by stress, a change in time zones or sleep schedule, poor bedtime habits, or an underlying medical or psychiatric condition.

Symptoms include:

- Difficulty falling asleep despite being tired
- Requiring sleeping pills or alcohol to fall asleep
- Awakening frequently during the night or lying awake in the middle of the night
- Awakening too early in the morning despite not feeling refreshed
- Daytime drowsiness, fatigue, and irritability

## Restless Legs Syndrome (RLS)

Restless legs syndrome (RLS) is a sensory disorder causing an almost irresistible urge to move the legs. The urge to move the legs is usually due to uncomfortable, tingly, or creeping sensations that occur when at rest. Movement eases the feelings, but only for a while. You may also notice small, jerky movements of the toes, feet, and legs as you are trying to fall asleep.

**Narcolepsy**

Narcolepsy is a disorder that causes a person to have difficulty staying awake. Narcolepsy can cause a person to suddenly fall asleep during the day. These "sleep attacks" occur even after getting enough sleep at night. The unusual sleep pattern that people with narcolepsy have can affect their schooling, work, and social life. Falling asleep during activities like walking, driving, cooking, or talking can have dangerous results, both professionally and personally.

Symptoms include:

- Intermittent, uncontrollable episodes of falling asleep during the daytime
- Excessive daytime sleepiness
- Sudden, short-lived loss of muscle control during emotional situations (cataplexy)

## Common tests for diagnosing sleep disorders

**Subjective Measurement of Sleepiness Form**- This sleep questionnaire asks you to rank whether certain situations make you sleepy and, if so, how sleepy.

**Overnight sleep study**- is a test that measures the electrical activity of your brain (electroencephalogram) and heart (electrocardiogram), and the movement of your muscles (electromyogram) and eyes (electro-oculogram), and usually requires an overnight stay at a sleep clinic for observation purposes.

Once you arrive to our facility, a team of sleep specialists will use the latest technology to monitor you while you sleep. You will be given a private room, where a technician will attach a variety of monitoring devices to your body once you are ready for bed. A sleep specialist will observe your sleep patterns using these devices, which monitor brain waves, heart rate, rapid eye movements, and more.

The next morning, the technician will remove all the monitoring devices, and you will be able to go straight to work or on to your daily activities. The sleep specialists will analyze the results from your sleep study and send your referring physician the results where he/she will go over and design a treatment program if necessary. If treatment of sleep apnea is necessary, you will be sent to a DME company for CPAP setup.


**SLEEP QUESTIONNAIRE**

**Patient Name: _____ Date: _____**

**DOB: _____ Age: _____ Patient ID: _____**

**Occupation: _____ Usual Work Hours/Days: _____**

**Referring Physician _____ Family Physician (PCP): _____**

**Marital Status: Single Married Divorced Widowed Sex: Female Male**

***Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.***

**My Main Sleep Complaint(s) Is:**

**_____trouble sleeping at night For how many months/years? _____**

**_____being sleepy all day For how many months/years? _____**

**_____snoring For how many months/years? _____**

**_____unwanted behaviors during sleep, explain _____**

**_____other, explain _____**

**Sleep Pattern**

| | Work Days (Weekday) | Off Days (Weekends) |
|---|---|---|
| **Typical bedtime:** | _____ | _____ |
| **Typical amount of time it takes to fall asleep:** | _____ | _____ |
| **Typical number of awakenings per night:** | _____ | _____ |
| **List any activities that you normally do during nighttime awakening(s) (i.e. restroom, eat, watch TV):** | _____ | _____ |
| **Typical amount of time to fall back asleep after an awakening:** | _____ | _____ |
| **Typical wake up time:** | _____ | _____ |
| **Desired wake up time:** | _____ | _____ |

**Patient Name: _____ Date: _____ Patient ID:_____**

| | | |
|---|---|---|
| **How often do you usually awaken? (i.e. alarm clock):** | _____ | _____ |
| **Typical time you get out of bed:** | _____ | _____ |
| **Total amount of sleep per night:** | _____ | _____ |
| **Number of naps per day:** | _____ | _____ |

**Please check all of the following statements that are true about your sleep:**

**Sleep Habits**

**_____ I usually watch TV or read in bed prior to sleep**
**_____ I frequently travel across 2 or more time zones**
**_____ I drink alcohol prior to bedtime**
**_____ I smoke prior to bedtime or when I awaken during the night**
**_____ I eat a snack at bedtime**
**_____ I eat if I awaken during the night**
**_____ I typically awaken to urinate during the night**
**_____ I have trouble falling asleep**
**_____ I awaken frequently during the night**
**_____ I am unable to return to sleep easily if I awaken during the night**
**_____ Thought start racing through my mind when I try to fall asleep**
**_____ I awaken early in the morning, still tired but unable to return to sleep**
**_____ I have nightmares as an adult**
**_____ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep**
**_____ I sweat a great deal during sleep**
**_____ I cannot sleep on my back**

**Breathing**

**_____ I have been told that I stop breathing while asleep**
**_____ I awaken at night choking, smothering or gasping for air**
**_____ I have been told that I snore**
**_____ I have been told that I snore only when sleeping on my back**
**_____ I have been awakened by my own snoring**

**Restlessness**

**_____ I am a restless sleeper**
**_____ I kick or jerk my legs and/or arms during sleep**
**_____ I experience restlessness, tingling, or crawling in my arms or legs**
**_____ I experience an inability to keep my legs still prior to falling asleep**
**_____ I talk in my sleep as an adult**
**_____ I have sleep walked as an adult**
**_____ I grind my teeth in my sleep**

**Daytime Sleepiness**

**_____ I take daytime naps**
**_____ I have a tendency to fall asleep during the day**
**_____ I have experienced lapses in time or blackouts**
**_____ I have fallen asleep while driving**
**_____ I have had auto accidents as a result of falling asleep while driving**

**Patient Name: _____ Date: _____ Patient ID: _____**

**_____ I fall asleep while watching TV**
**_____ I fall asleep during conversations**
**_____ I fall asleep during sedentary situations**
**_____ I performed poorly in school because of sleepiness**
**_____ I have had injuries as the result of sleepiness**
**_____ I have experienced sudden muscle weakness in response to emotions such as laughter, anger, or surprise**
**_____ I have experienced an inability to move while falling asleep or when waking up**
**_____ I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up**
**_____ I drink caffeinated beverages during the day _____ cups/bottles/cans per day**

**Habits**

**Do you smoke? ☐ Yes ☐ No**

**`**

| *If yes:* | **What?** | **Amount Per Day** | **For How Many Years** |
|---|---|---|---|
| ☐ | **Cigarettes** | **_____ pack(s)** | **_____ years** |
| ☐ | **Cigars** | **_____ cigars** | **_____ years** |
| ☐ | **Tobacco** | **_____ pipes** | **_____ years** |

**Do you drink alcohol? ☐ Yes ☐ No**

| *If yes:* | **What?** | **Frequency** | | | |
|---|---|---|---|---|---|
| ☐ | **Beer** | ☐ **Daily** | ☐ **Weekends** | ☐ **Rare** | **_____ cans/week** |
| ☐ | **Wine** | ☐ **Daily** | ☐ **Weekends** | ☐ **Rare** | **_____ glasses/week** |
| ☐ | **Liquor** | ☐ **Daily** | ☐ **Weekends** | ☐ **Rare** | **_____ shots/week** |

**Social History**
**Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed**

**_____ sleep alone**
**_____ share a bed with someone**
**_____ share a bedroom, but have separate beds**
**_____ share a dwelling, but have separate bedrooms**

**Employment Status: ☐ Employed ☐ Unemployed ☐ Retired**
**_____ my job requires driving a vehicle**
**_____ I work with dangerous equipment or substances**
**_____ I am a shift worker on rotating shifts**
**_____ I am a permanent or long term third shift worker**
**_____ I am currently a student**

**Patient Name: _____ Date: _____ Patient ID: _____**

# Medical History

**Vital Statistics**

**What is your: Height _____ Weight _____ Neck Size _____**
**What was your weight one year ago? _____ Five years ago _____**

**Current Medications**

| Medication | Dose | # Times Per Day | Medication | Dose | # Times Per Day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Allergies: _____**

**Past Sleep Evaluation and Treatment**

**_____ I have had a previous sleep disorder evaluation**
**_____ I have had previous overnight sleep studies**
**_____ I have had daytime nap studies**
**_____ I have been prescribed a CPAP or Bi-Level machine for home use**
**_____ I have had surgical treatment for a sleep disorder**
**_____ I have previously been prescribed medication for a sleep disorder**
**_____ I have been previously treated for a sleep disorder**

**Past Medical History**

**_____ Hypertension**
**_____ Heart Disease**
**_____ Diabetes**
**_____ Stomach or colon problems**
**_____ Lung problems/COPD/asthma**
**_____ Reflux**
**_____ Fibromyalgia**
**_____ Stroke**
**_____ TIA "Light Stroke"**
**_____ Blackouts**
**_____ Seizures**
**_____ Back or joint problems (arthritis)**
**_____ Cancer**
**_____ Thyroid problems**
**_____ Hepatitis/jaundice**
**_____ Hearing impairment**
**_____ Depression or severe anxiety**
**_____ Alcoholism**
**_____ Chemical dependency or abuse**

**Female**

**_____ Premenstrual Syndrome**
**_____ Menopause**

**Male**

**_____ Prostate problems**
**_____ Erectile dysfunction/impotence**

**List other past medical problems and dates:**

| | |
|---|---|
| | |
| | |
| | |

**Patient Name: _____ Date: _____ Patient ID:_____**

**List Surgeries and the year**

_____ _____

_____ _____

_____ _____

**In the PAST 12 MONTHS check any of the following symptoms you have had:**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | **Frequent headaches** | ☐ | ☐ | **Frequent heartburn or indigestion** |
| ☐ | ☐ | **Fainting or passing out** | ☐ | ☐ | **Abdominal pain** |
| ☐ | ☐ | **Sudden loss of vision or strength** | ☐ | ☐ | **Frequent constipation** |
| ☐ | ☐ | **Inability to speak** | ☐ | ☐ | **Frequent diarrhea** |
| ☐ | ☐ | **Hearing loss or ringing in the ear(s)** | ☐ | ☐ | **Rectal bleeding / black stools** |
| ☐ | ☐ | **Hoarseness for more than 2-4 weeks** | ☐ | ☐ | **Difficulty urinating / incontinence** |
| ☐ | ☐ | **Nosebleeds** | ☐ | ☐ | **Blood in urine** |
| ☐ | ☐ | **Cough for more than 2-4 weeks** | ☐ | ☐ | **Urinating more than 2 X per night** |
| ☐ | ☐ | **Coughing up blood** | ☐ | ☐ | **Pain in joints and bones** |
| ☐ | ☐ | **Shortness of breath or wheezing** | ☐ | ☐ | **Unusual bruising or bleeding** |
| ☐ | ☐ | **Swelling in feet or ankles** | ☐ | ☐ | **Convulsions** |
| ☐ | ☐ | **Chest pain, pressure, or heaviness** | ☐ | ☐ | **Change in wart, mole, or skin growth** |
| ☐ | ☐ | **Irregular heartbeat or sudden fast heartbeat** | ☐ | ☐ | **Weight loss of more than 5-10 pounds** |
| ☐ | ☐ | **Difficulty swallowing or food "sticking"** | | | |

**Family History**

**Has an immediate blood relative had any of the following?**

| Yes | No | Relation | | Yes | No | Relation | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | **Cancer** | _____ | ☐ | ☐ | **Stroke** | _____ |
| ☐ | ☐ | **Diabetes** | _____ | ☐ | ☐ | **Anxiety/Depression** | _____ |
| ☐ | ☐ | **Hypertension** | _____ | ☐ | ☐ | **Sleep Apnea** | _____ |
| ☐ | ☐ | **Heart Disease** | _____ | ☐ | ☐ | **Narcolepsy** | _____ |
| ☐ | ☐ | **Thyroid Disease** | _____ | ☐ | ☐ | **Other:** | _____ |

# Epworth Sleepiness Scale

**Patient: _____ Date: _____ Patient ID: _____**

## 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** | |


**Patient Information:** **Date:** _____

Patient Name: _____ DOB: _____ Age: _____

Ht_____ LBS_____ Referring Physician_____

Primary Care Physician_____ PCP Phone # _____ PCP Fax # _____

Gender: ☐ Male ☐ Female SS#: _____ Marital Status ☐S ☐M ☐D ☐W

Address: _____ City: _____ Zip: _____

**Please check the contact number preferred to be reached on:**
☐Home Phone: _____ ☐Work Number:_____ ☐ Cell Number: _____

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

**Primary Insurance Carrier**:_____ Policy I.D. #: _____

Policy Group #: _____ Insurance Phone Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

**Secondary Insurance Carrier**:_____ Policy I.D. #: _____

Policy Group #: _____ Insurance Phone Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

**Employment Information:**

☐ **N/A** Patients Employer_____ Work Ph# _____
**If the patient is a minor,** please list guardian information:
☐ **N/A** Guardian: _____ Employer _____ 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: _____

**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 known as Acquired Immune Deficiency Syndrome (AIDS).

**Advance Directive**
Sleep Solutions does not honor advance directives. In the event of an emergency life saving attempts will be made.

**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, including physicians, with whom Sleep solutions can discuss your health care information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I agree to waive my advance directive while at Sleep Solutions.
Signature _____

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

A copy of your sleep study is available upon signed request or by contacting your physician's office.

_____ _____
Patient (or Parent/Guardian or Representative) Date

_____ _____
Relationship to Patient Witness

# Patient Bill of Rights and Responsibilities

**Sleep Solutions is committed to treating our patients with the utmost respect and highest quality of care. It is our pledge to treat all of our patients in a dignified and respectful manner. Sleep Solutions will respect each patient's right to and need for effective communication. Furthermore, each patient shall receive information that is in a manner tailored to the patient's age, language, and ability to understand.**

**Our organization shall provide interpreting and translation services as necessary to accommodate the needs of our patients. Sleep Solutions shall effectively communicate with patients who have vision, speech, hearing, or cognitive impairments in a manner that meets the individual patient's needs.**

**Sleep Solutions will respect the patient's cultural and personal values, beliefs, and or preferences. The organization and its staff will respect the patient's right to privacy as outlined in the Patient Privacy Notice. A copy of the Patient Privacy Notice is provided to each patient.**

**Medication is not dispensed or stored at the sleep lab. In the event of pain, Sleep Solutions will respect the patient's rights to pain management. When warranted by the patient's condition, Sleep Solutions staff will consult with the staff Medical Director to develop a comprehensive plan for the needs of the patient. Sleep Solutions will use methods to assess patient pain that are consistent with patient's age, condition and ability to understand. Sleep Solutions will reassess and respond to the patient's pain, based on the assessment criteria. In the event the patient's pain requires treatment, the Medical Director will refer patient to the appropriate facility for pain management.**

**Sleep Solutions will involve patients in decision making regarding his or her care, treatment, or services. Our organization will respect the patient's right to refuse care, treatment, or services when in accordance with laws and regulation. In the event the patient is unable to make decisions regarding his or her care Sleep Solutions will involve the surrogate decision-maker. Sleep Solutions will respect the decision-makers rights to refuse care, treatment, or services on the patient's behalf in accordance with current law and regulation.**

**Sleep Solutions does not honor advance directives and will administer life saving methods in the event of an emergency.**

**Sleep Solutions will allow patients to access, request amendment to, and obtain information on disclosures of his or her health information in accordance with laws and regulations. Such regulations are further outlined in Patient Privacy Notice.**

**If you have any questions or concerns regarding the above Bill of Rights, please contact our Compliance Officer, Jamie Beaty at 405-600-1261.**

**NOTICE OF PRIVACY PRACTICES** **PATIENT COPY**

**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.

Our Responsibilities

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.

How We Will Use or Disclose Your Health Information

(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, 409 E California Ave., Oklahoma City, OK 73104. 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 call 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.