AMERICAN
SLEEP MEDICINE

To our Patients,

We are looking forward to seeing you for your sleep study. We thought you might like some additional information about your upcoming experience in advance. In addition to the advance information, our Patient Packet is also included. Please complete all the documentation and bring it with you to the center for your appointment.

The document titled "Items to Bring for Your Sleep Study" will help you prepare for what you do and don't need to bring with you the evening of your study. You can also obtain more information about sleep disorders and what to expect during a test from our website: www.americansleepmedicine.com.

American Sleep Medicine is one of the nation's largest integrated sleep diagnosis and testing companies. We pride ourselves in providing the highest level of service through every step of the process, including: testing, diagnosing, and treating sleep disorders through our American Sleep Products equipment and supply division should you require treatment.

Please feel free to contact your local American Sleep Medicine center staff with any questions about your upcoming study.

Sincerely,

The American Sleep Medicine Team

AMERICAN
SLEEP MEDICINE

ITEMS TO BRING FOR YOUR SLEEP STUDY

Please review the list below and feel free to ask our center team if you have any questions:

***ITEMS TO BRING:**

1. Driver's License
2. Insurance Card
3. Medication
4. Medication List
5. Light Overnight Bag
6. Reading Material\Glasses
7. 2 Piece Pair of Pajamas
8. Toothbrush\Mouthwash
9. Shampoo\Conditioner
10. Personal Hygiene Products
11. Slippers (if you choose)
12. Any out of pocket payment due

ITEMS & SERVICES WE PROVIDE:

1. Satellite Television
2. Adjustable Reverie Bed
3. Muffins/Coffee/Juice in the Morning
4 Intercom Service
5. Reading Lamp
6. Overnight Baggage Storage
7. Registered Technicians & Respiratory Therapists
8. Bi-Lingual Staff
9. Private Room for your Caretaker to Stay (if needed)
10. Free Parking & Security
11. Bathroom
12. Emailed or Faxed Paperwork

UPON REQUEST, WE HAVE:

1. Female or Male Technician
2. Extra Blankets
3. Extra Pillows
4. Extra Towels
5. Night Light
6. Portable Fan
7. Clothes Hangers
8. Disposable Razor
9. Toothpaste\Mouthwash
10. Plastic Water Cups
11. Bottled Water\Soda\Coffee
12. Portable Heater
13. Ear Plugs

DO NOT BRING:

1. Valuables (jewelry or large sums of money)
2. Perishable Food
3. Strong Perfumes or Cologne
4. Alarm Clock (we will wake you up)
5. Pets (does not apply to service animals)

Please let us know if you have any disabilities or special needs that we should know about prior to your study. Due to the product we use to attach each lead, you will need to wash your hair following the study. If there is anything else we can do to make your stay more enjoyable, do not hesitate to ask. We want to provide you with the best experience possible!

Sincerely,

The American Sleep Medicine Team

AMERICAN SLEEP MEDICINE

Referring Physician: _____

Date: _____

PATIENT INFORMATION

Name of Patient: _____ Male _____ Female _____

Home Address: _____ City: _____ St: _____ Zip: _____

Circle One: Single Married Divorced Separated Widowed

Home Phone including Area Code ( ) _____ Cell Phone: ( ) _____

Social Sec #: _____ Age: _____ Date of Birth: _____

Employment (if applicable): _____ Business Phone: _____

Employer's address: _____ City: _____ St: _____ Zip: _____

Nearest Relative (not at same address as patient): _____ Relationship: _____ Phone: _____

GUARDIAN INFORMATION (If Patient is a Minor)

Name: _____ Male_____ Female _____

Home Address: _____ City: _____ St: _____ Zip:_____

Circle One: Single Married Divorced Separated Widowed

Home Phone including Area Code ( ) _____ Cell Phone: ( ) _____

Social Sec #: _____ Age: _____ Date of Birth: _____

Employment (if applicable): _____ Business Phone: _____

Employer's address: _____ City: _____ St: _____ Zip: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

Insurance ID: _____ Group Number: _____

Subscriber Name: (person to whom the policy originates): _____

Subscriber Date of Birth (*): _____ Subscriber Social Sec # (*):_____

Patient Relationship to Subscriber: (check one) ____self ____spouse ___ child ___other

Effective Date of Policy: _____

SECONDARY INSURANCE INFORMATION (if applicable):

Insurance Company Name: _____

Insurance ID: _____ Group Number: _____

Subscriber Name: (person to whom the policy originates):_____

Subscriber Date of Birth (*): _____ Subscriber Social Sec # (*):_____

Patient Relationship to Subscriber: (check one) ____self ____spouse ___ child ___other

Effective Date of Policy: _____

*** <u>TRICARE:</u> IF THE PRIMARY INSURANCE IS TRICARE, WE MUST HAVE THE SOCIAL SECURITY NUMBER AND DATE OF BIRTH OF THE INSURANCE SPONSOR IN ORDER TO FILE A CLAIM ON YOUR BEHALF.**

**** A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED TO BE PRESENTED ON OR BEFORE THE DATE OF SERVICE.**

Version 1.27.17

AMERICAN SLEEP MEDICINE

DISCLOSURES AND AUTHORIZATIONS

Name: _____

(please print name above and initial each section)

Patient Consent for Treatment

_____ I am requesting American Sleep Medicine ("ASM") to test me for possible sleep disorders and I authorize ASM to provide such tests as set forth in the physician order.

_____ I understand that photographs, video, digital or other images may be recorded to document my care and I explicitly provide my consent. I understand ASM retains the ownership rights to any such recorded images and I understand I am able to view or obtain copies. I understand these recorded images will be stored in a secure manner to protect my privacy as part of my medical record and will be kept for the time required by law.

_____ I acknowledge I have consulted my physician and understand the nature of the test(s) and consent to such sleep tests.

Patient Assignment of Benefits Agreement

_____ I authorize direct remittance of payment of all insurance or Medicare benefits to ASM for all covered services, and I authorize ASM to act as my Designated Representative concerning all aspects of insurance claim filing, including, but not limited to, appeals for products or services rendered by ASM. I understand and agree that my Assignment of Benefits will have continuing effect for as long as I am receiving services from ASM. I authorize my insurance company to mail ALL PAYMENTS directly to ASM.

_____ I understand that I ultimately have the financial responsibility for the payment of all fees associated with the services provided by ASM. I will be responsible for all charges not covered by my insurance and <u>if I receive any payment from my insurance carrier directly for services rendered by ASM, I</u> <u>will immediately forward such payment to ASM</u>.

_____ I understand the Estimated Out of Pocket Expenses are due prior to receiving any services or products. The ASM billing department can be reached directly at 1-877-526-8296 for any billing-related questions.

_____ I understand that the physician's consult, follow-up, and reading of the study will be billed separately.

Past Due Accounts

_____ I understand that a fee may be charged by ASM on all accounts that are 90 days or more past due. ASM may charge interest on any outstanding balance more than 90 days past due at a rate of one half (1/2) percent per month. I understand the interest rate fee may be added to any account that is more than 90 days past due and hereby agree to pay any and all such charges. I also understand that in the event my account is placed with a collection agency, and/or a lawsuit is brought against me to collect any
outstanding balance due ASM, I will be responsible for all costs of collections, including, but not limited to, court costs and reasonable attorney fees.

Reschedule/No-Show Fee

_____ I understand that if I do not notify ASM more than 24 hours prior to my scheduled test appointment that I cannot attend, I may be charged $75.00 fee.

Commercial Drivers

_____ I understand if I am diagnosed with a sleep disorder, the agency that has issued my commercial driver's license may be contacted if I do not follow my doctor's instructions and recommendations or if I am not compliant with my treatment plan.

Receipt of Notice of Privacy Practices, Patient Rights and Responsibilities, and Provider Performance Standards

_____I have received and reviewed the attached Notice of Privacy Practices, the Patient Rights and Responsibilities, and the Provider Performance Standards; I understand my rights as stated in these documents.

I have read all of the above and have initialed in the appropriate locations acknowledging I have read and I understand each section. My initials and signature represent my unqualified acceptance and acknowledgement of each of the above statements. I authorize a copy of this form to be used in place of the original.

Signature: _____ **Date:** _____

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Patient Consent for Use and Disclosure of Protected Health Information

This request of your consent will not restrict the normal use or disclosure of your protected health information necessary by American Sleep Medicine for the purpose of providing treatment, obtaining payment or supporting the day-to-day health care operations of the clinic.

By signing this disclosure, I consent that the clinic may call my home or other designated location and leave a message on voicemail or in-person in reference to appointment reminders and insurance items. In addition, the clinic may mail to my home appointment reminders and patient statements.

I designate the following individual(s) who the clinic staff or billing staff can communicate with on my behalf. If I do not designate anyone, I understand that the clinic staff or billing staff will be unable to speak with anyone regarding my medical condition or insurance billing.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Signature:

_____ _____

Patient or Legal Representative Signature Date

_____

Print Name of Patient or Legal Representative

AMERICAN
SLEEP MEDICINE

AUTHORIZATION
FOR MINOR PATIENTS
(UNDER 18 YEARS OF AGE)

I authorize the treatment of my minor child, _____, by American Sleep Medicine.

I understand that as the parent/guardian presenting this minor for treatment, I am personally financially responsible for payment of the account, regardless of any divorce, custody order or legal arrangements.

I authorize American Sleep Medicine to act as my agent in helping me obtain payment from this minor's insurance companies.

I authorize use of this form on all insurance submissions.

I authorize release of information (including the minor's health information and billing information) regarding all services rendered.

I understand it is my responsibility to obtain a referral from this minor's primary care physician (if required by the insurance company) and that if payment is not made due to lack of a referral, I am personally financially responsible for payment of the account.

I authorize a copy of this Authorization to be used in place for the original.

_____	_____	_____
Parent/ Guardian Signature	Parent/Guardian Printed Name	Date

AMERICAN SLEEP MEDICINE

ADMISSIONS

Sleep Questionnaire

It is important that you fill out this sleep questionnaire completely and as accurately as possible. Please answer each question. The questionnaire is a broad-based screening tool that will assist our staff and your treating sleep physician to provide excellent care to you. It may be helpful to consult with a family member or bed partner when answering these questions. All information contained in this questionnaire will become a part of your medical record and will be confidential.

DEMOGRAPHIC DATA:

Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Male: _____ Female: _____

PHYSICIAN INFORMATION:

Primary Physician: _____ Requesting Physician: _____

Address: _____ Address: _____

_____ _____

Phone: _____(_____)_____ Phone: _____(_____)_____

Specialty: _____ Specialty: _____

SLEEP SCHEDULE:

	Bedtime	Wake time	Average amount of sleep per night
Weekday:	_____ am/pm	_____ am/pm	_____ hours
Weekends:	_____ am/pm	_____ am/pm	_____ hours

Do you wake up feeling rested? YES_____ NO_____

Do you currently use CPAP treatment at night? YES_____NO_____ Pressure: _____

Do you have rotating or night shift work? YES _____NO_____

How long does it take you to go to sleep?_____hours_____minutes

How many times a night do you wake up from sleep? ____Do you fall back to sleep easily? _____

Do you nap? _____ If so, how often? _____

SLEEP HISTORY:

Describe the problem you are experiencing with your sleep and when it first began:

□YES □NO Do you experience excessive daytime sleepiness?

□YES □NO Are you a restless sleeper?

□YES □NO Has anyone told you that you snore? For how long? _____

□YES □NO Do you snore sleeping in all positions? For how long? _____

□YES □NO Has your family told you that you quit breathing at night? For how long? _____

□YES □NO Have you ever awakened gasping for breath? For how long? _____

□YES □NO Do you awaken with mouth dryness? For how long? _____

□YES □NO Do you have morning headaches? For how long? _____

□YES □NO Has your weight changed in the last 5 years? Gained _____ Lost _____

□YES □NO Do you have "tingly" legs and feel as if you have to move them? For how long?_____

□YES □NO Do you kick your legs at night? For how long? _____

□YES □NO Do you sleep better away from your own bed? (ie: vacation)For how long? _____

□YES □NO Do you have pain that bothers you at night? For how long? _____

□YES □NO Do you grind your teeth in your sleep? For how long? _____

□YES □NO Do you sleep walk? For how long? _____

□YES □NO Do you talk in your sleep? For how long? _____

□YES □NO Have you ever experienced periods in which you feel paralyzed while you are going to sleep or waking up? For how long? _____

□YES □NO Have you ever had a hallucination or dream-like mental images when falling asleep? For how long? _____

□YES □NO Have you ever experienced sudden physical weakness during strong emotions? (ie: legs going limp while laughing or when angry) For how long? _____

□YES □NO Do you have difficulty staying awake to drive? For how long? _____

□YES □NO Have you ever had an automobile accident due to sleepiness?
Date of Accident ___/____/____

PAST MEDICAL HISTORY:

Please check all that apply:

□ Allergies –Please list_____

□ Tonsillectomy	□ Hernia repair	□ Appendectomy	□ Cardiac Bypass	□ Hysterectomy
□ Orthopedic surgery	□ Cardiac Cath	□ Nasal surgery	□ Emphysema	□ Asthma
□ Diabetes	□ Heart Disease	□ Lung Disease	□ Arthritis	□ Ulcers
□ Thyroid Disease	□ Seizure Disorder	□ High blood pressure	□ High Cholesterol	
□ GERD / Reflux	□ Other: _____			

MEDICATIONS:

Name:	Dose:	Name:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over the counter medications: _____

Medication Allergies: _____

Are you currently using supplemental oxygen □ YES □ NO If yes, _____LPM

SOCIAL HISTORY:

Caffeine:
How much caffeine do you consume on a daily basis?
□ Caffeinated beverage (cola, soda, etc.)
How many cans per day?____
□ Tea or Coffee
How many cups per day?____

Tobacco:
□ Never
□ Quit
□ Currently Smoke
□ Currently Chew

How many packs per day? ____
How many years? _____

Home:
□ married
□ divorced
□ widowed
□ single
□ children
How many children?____

Alcohol: □ Never
□ Quit
□ Occasionally
□ Daily
□ Beer
□ Liquor
□ Cocktails

Illicit Drugs: □ Never
□ Quit
□ Occasionally
□ Daily
What are you using?
_____

Work: □ retired
□ disabled
□ student
□ currently employed
□ work day
□ work nights
□ shift work
Occupation? _____

FAMILY HISTORY: *Family History including father, mother, and siblings:*

			Person with disorder				Person with disorder
Diabetes	□YES	□NO	_____	Obesity	□YES	□NO	_____
High B/P	□YES	□NO	_____	Snoring	□YES	□NO	_____
Stroke	□YES	□NO	_____	Sleep Apnea	□YES	□NO	_____
Narcolepsy	□YES	□NO	_____	Daytime Fatigue	□YES	□NO	_____
Depression	□YES	□NO	_____	Anxiety	□YES	□NO	_____

SYMPTOMS REVIEW:

(please circle Yes or No for each option below)

Constitutional Review:

Yes No Fever
Yes No Night Sweats
Yes No Unexplained weight loss/gain

Ear, Nose and Throat Review:

Yes No Hearing Loss
Yes No Hoarseness
Yes No Sore Throat
Yes No Nasal Congestion

Pulmonary Review:

Yes No Coughing
Yes No Shortness of breath
Yes No Difficulty breathing lying flat
Yes No Difficulty breathing at night
Yes No Wheezing
Yes No Coughing up blood
Yes No History of positive TB skin test

Musculoskeletal Review:

Yes No Muscle aching
Yes No Joint Pain

Endocrine Review:

Yes No Excessive thirst
Yes No Skin moistness or dryness
Yes No Heat intolerance
Yes No Cold intolerance

GYN Review:

Yes No Post-menopausal
Yes No I am or could now be pregnant

Cardiac review:

Yes No Chest Pain
Yes No Ankle Swelling
Yes No Heart Murmur

GI Review:

Yes No Black Stools or bleeding from bowels
Yes No Nausea/Vomiting
Yes No Trouble Swallowing
Yes No Abdominal Pain

GU Review:

Yes No Frequent bladder infections
Yes No Painful urination
Yes No Frequent urination
Yes No Blood in urine
Yes No Night time urination
Yes No Loss of bladder control
Yes No Difficulty starting stream of urine

Skin Review:

Yes No Skin Rash
Yes No Easy bruising

Psychosocial / Social review:

Yes No Loss of appetite
Yes No Feeling depressed
Yes No Anxiety
Yes No Agitation
Yes No Increased stress/trouble at work

Neurological Review:

Yes No Paralysis
Yes No Numbness/Weakness in hands, feet, or legs
Yes No Trouble with balance
Yes No History of stroke
Yes No Difficulty with concentration
Yes No Seizures
Yes No Headaches

Other complaints not mentioned above:

_____

_____

_____ _____ _____

Patient Signature **Printed Name** **Date**

*Physician Signature*_____ *Date:* _____

Your physician has asked that you complete the following Epworth Sleepiness Scale. Your answers to the questions below will be used to measure how sleepy you are generally, and will be used by your physician as an aid in determining your diagnosis and treatment.

Epworth Sleepiness Scale

Name: _____ Today's Date: _____

Your Age (Yrs): _____Your Sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the certain situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. If you have not done some of these things recently, think about how they have affected you in the past.

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

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	____
Watching TV	____
Sitting, inactive in a public place (e.g. a theatre 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 the traffic	____

THANK YOU FOR YOUR COOPERATION

AMERICAN SLEEP MEDICINE

HEALTH INFORMATION RELEASE AUTHORIZATION (OPTIONAL)

NAME:_____
_____

DOB: _____SS#: _____
_____

ADDRESS:_____
_____

CITY: _ _____ STATE: _____ ZIP:_____ _____

DAY/WORK TELEPHONE ( )

RELEASE INFORMATION – CHOOSE ONE BOX

☐ I authorize American Sleep Medicine to RELEASE medical records information to:

☐ I authorize American Sleep Medicine to OBTAIN medical records information from:

NAME: _____

ADDRESS: _____

CITY: STATE ZIP

PURPOSE FOR REQUEST

Continued Care Attorney Personal Use Insurance Claim ☐ Other _____

I understand that I am entitled to ONE FREE COPY of my medical records during my lifetime. Any additional copies sent for any reason are subject to a copy fee of $1 per page.

This is the first requested copy of my medical records ☐ YES ☐ NO

INFORMATION NEEDED

Entire Medical Records ☐ Progress Notes from date _____to _____

Laboratory Results ☐ Test results Other _____

I understand that the information in my health record may include information related to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behaviors or mental health services and treatment for alcohol and/or drug abuse.

AUTHORIZATION

This authorization is effective for the duration of my treatment unless revoked or terminated by the patient or the personal representative. It is understood that my records may not be released to me at the same time as requested. It can take anywhere from 24 hours to 30 days from the time of the request

.

I may revoke or terminate this authorization by contacting American Sleep Medicine in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information is in compliance with the Health Insurance Privacy and Portability Act of 1996 (HIPPA).

_____

Patient Signature/Authorized Representative Relationship to Patient Date

_____

Witness Signature Date

AMERICAN SLEEP MEDICINE

PATIENT RIGHTS & RESPONSIBILITIES

As a patient of American Sleep Medicine, you have the right:

- To be treated with dignity and compassion and to have your privacy and property respected at all times; and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by our staff.
- To privacy and confidentiality of all records pertaining to your care, except as otherwise provided by law, and to have access to those records upon request.
- To receive care and services in a professional manner without discrimination on the basis of your age, sex, race, religion, ethnic origin, sexual preference, physical or mental handicap, or personal, cultural and ethnic preferences.
- To obtain complete and clear information concerning diagnosis, treatment and prognosis.
- To exercise your rights as a client, such as providing informed consent, or to have your authorized, designated representative exercise your rights as a client.
- To participate in the development and modification of your care and service plan; to refuse treatment, within the boundaries set by law, and to be informed of the consequences of any such refusal.
- To be informed of the services available at our facility, who will be providing care, and the fees and charges for such services and products provided.
- To be informed of any experimental treatment or research study and to refuse to participate in these projects.
- To express concerns, grievances or recommendations without fear of discrimination or reprisal and to be involved, as appropriate, in discussions and resolutions of conflicts and/or ethical issues related to your care. Please report all concerns or grievances to the administrator of this facility or you may contact our Chief Compliance Officer using our Ethics Line: 1-855-282-4967.

And you have the responsibility:

- To keep appointments and when unable to do so, notify us immediately.
- To be considerate of other patients and personnel, and to control noise and other distractions while at our facility.
- To respect the privacy and property of others and the facility.
- To notify us when you feel ill, or encounter any unusual physical or mental stress or sensations while at our facility.
- To provide complete and accurate information concerning your health, medications, allergies, and other matters related to your healthcare and treatment.
- To notify us of any changes to your insurance coverage, place of residence, telephone number or medical history.
- To request additional assistance or information on any phase of your health care plan you do not fully understand.
- To actively participate in decisions about your healthcare and comply with treatment regimens.
- To promptly fulfill financial obligations to this facility by making payments when due, or by providing documentation or information to this facility in order to complete insurance claim filing.

AMERICAN SLEEP MEDICINE

Notice of Privacy Practices

If you have questions regarding this Notice, or a complaint, you may contact our Chief Compliance Officer at 1-855-875-3372.

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your medical record

- You can ask to see or get a copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights; contact us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

We can use and share your health information to run our clinic, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date: December 15, 2013
- You may contact our Chief Compliance Officer directly: 1-855-875-3372 or you may call our Ethics Line: 1-855-282-4967; the Ethics Line allows you to call anonymously if you choose.

INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF) PERFORMANCE STANDARDS

Below is a list of the performance standards that an IDTF must meet in order to obtain or maintain their Medicare billing privileges. These standards, in their entirety, can be found in 42 C.F.R section 410.33(g).

1. Operate its business in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients.

2. Provides complete and accurate information on its enrollment application. Changes in ownership, changes of location, changes in general supervision, and adverse legal actions must be reported to the Medicare fee-for-service contractor on the Medicare enrollment application within 30 calendar days of the change. All other changes to the enrollment application must be reported within 90 calendar days.

3. Maintain a physical facility on an appropriate site. For the purposes of this standard, a post office box, commercial mail box, hotel or motel is not considered an appropriate site.

    (i) The physical facility, including mobile units, must contain space for equipment appropriate to the services designated on the enrollment application, facilities for hand washing, adequate patient privacy accommodations, and the storage of both business records and current medical records within the office setting of the IDTF, or IDTF home office, not within the actual mobile unit.

    (ii) IDTF suppliers that provide services remotely and do not see beneficiaries at their practice location are exempt from providing hand washing and adequate patient privacy accommodations.

4. Have all applicable diagnostic testing equipment available at the physical site excluding portable diagnostic testing equipment. A catalog of portable diagnostic equipment, including diagnostic testing equipment serial numbers, must be maintained at the physical site. In addition, portable diagnostic testing equipment must be available for inspection within two business days of a CMS inspection request. The IDTF must maintain a current inventory of the diagnostic testing equipment, including serial and registration numbers, provide this information to the designated fee-for-service contractor upon request, and notify the contractor of any changes in equipment within 90 days.

5. Maintain a primary business phone under the name of the designated business. The primary business phone must be located at the designated site of the business, or within the home office of the mobile IDTF units. The telephone number or toll free numbers must be available in a local directory and through directory assistance.

6. Have a comprehensive liability insurance policy of at least $300,000 per location that covers both the place of business and all customers and employees of the IDTF. The policy must be carried by a non-relative owned company. Failure to maintain required insurance at all times will result in revocation of the IDTF's billing privileges retroactive to the date the insurance lapsed. IDTF suppliers are responsible for providing the contact information for the issuing insurance agent and the underwriter. In addition, the IDTF must –

    (i) Ensure that the insurance policy must remain in force at all times and provide coverage of at least $300,000 per incident; and

    (ii) Notify the CMS designated contractor in writing of any policy changes or cancellations.

7. Agree not to directly solicit patients, which include, but is not limited to, a prohibition on telephone, computer, or in-person contacts. The IDTF must accept only those patients referred for diagnostic testing by an attending physician, who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Nonphysician practitioners may order tests as set forth in §410.32(a)(3).

8. Answer, document, and maintain documentation of a beneficiary's written clinical complaint at the physical site of the IDTF (For mobile IDTFs, this documentation would be stored at their home office.) This includes, but is not limited to, the following:

    (i) The name, address, telephone number, and health insurance claim number of the beneficiary.

    (ii) The date the complaint was received; the name of the person receiving the complaint; and a summary of actions taken to resolve the complaint.

    (iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

9. Openly post these standards for review by patients and the public.

10. Disclose to the government any person having ownership, financial, or control interest or any other legal interest in the supplier at the time of enrollment or within 30 days of a change.

11. Have its testing equipment calibrated and maintained per equipment instructions and in compliance with applicable manufacturers suggested maintenance and calibration standards.

12. Have technical staff on duty with the appropriate credentials to perform tests. The IDTF must be able to produce the applicable Federal or State licenses or certifications of the individuals performing these services.

13. Have proper medical record storage and be able to retrieve medical records upon request from CMS or its fee-for-service contractor within 2 business days.

14. Permit CMS, including its agents, or its designated fee-for-service contractors, to conduct unannounced, on-site inspections to confirm the IDTF's compliance with these standards. The IDTF must be accessible during regular business hours to CMS and beneficiaries and must maintain a visible sign posting the normal business hours of the IDTF.

15. With the exception of hospital-based and mobile IDTFs, a fixed base IDTF does not include the following:

    (i) Sharing a practice location with another Medicare-enrolled individual or organization.

    (ii) Leasing or subleasing its operations or its practice location to another Medicare enrolled individual or organization.

    (iii) Sharing diagnostic testing equipment using in the initial diagnostic test with another Medicare-enrolled individual or organization.

16. Enrolls in Medicare for any diagnostic testing services that it furnishes to a Medicare beneficiary, regardless of whether the service is furnished in a mobile or fixed base location.

17. Bills for all mobile diagnostic services that are furnished to a Medicare beneficiary, unless the mobile diagnostic service is part of a service provided under arrangement as described in section 1861(w)(1) of the Act.