Integrative Insomnia & Sleep Health Center, Inc.

6725 Mesa Ridge Road #224
San Diego, CA 92121
Tel: 858.224.1866 | Fax: 858.524.5937
www.integrativesleep.com

CONFIDENTIAL

Today's DATE:

First Name:		Last Name:		Mid Init.
Street Address:			Age:	DOB: / /
City:	ST:	ZIP:	SSN:	
Home Tel: ( )	Work: ( )		Cell Phone: ( )	
Which is the best number to reach you at?				

Do you authorize us to leave messages with your detailed medical information at this number? Circle one: yes / no

Email:
Do you authorize us to Email you with your detailed medical information at this Email? Circle one: yes / no

Height: ft. in.			Weight: lbs.				
Marital Status:	*Single*	*Married*	*Living w/ Partner*	*Divorced*	*Widowed*		
Patient Race: (Optional)	*Asian*	*Black*	*Cauc*	*Hisp*	*Native Amer*	*Pac Isl*	*Other:*
Current Occupation:				Gender:	M	F	

Emergency Contact:	Tel: ( )	Relationship:
How did you hear about us? *Healthcare Provider* *Friend* *Internet* *Other:*		

REFERRING HEALTHCARE PROVIDER:

Referring Provider:		*MD DO DDS DMD PA NP*
Street Address:		
City: ST:	ZIP:	Specialty:
Office Tel: ( )	Office Fax: ( )	Office Contact:

PRIMARY HEALTHCARE PROVIDER (IF DIFFERENT FROM YOUR REFERRING PROVIDER):

Primary Provider:		*MD DO DDS DMD PA NP*
Street Address:		
City: ST:	ZIP:	Specialty:
Office Tel: ( )	Office Fax: ( )	Office Contact:

INSURANCE INFORMATION

Patient First Name:	Last Name:	Mid Init.

Primary Insurance: ____

Secondary Insurance: ____

*** PLEASE BRING YOUR INSURANCE CARDS TO EACH VISIT ***

Responsible Party:

Are you the responsible party (Named Subscriber) of your insurance plan? YES NO If **YES**, skip this section If **NO**, please complete this section:			
Responsible party of your insurance plan: First Name: Last Name: Relationship to Patient: Spouse Parent Other:			
Address:	City:	State:	ZIP:
Home# ( )	Work # ( )	Cell # ( )	
Employer:		Occupation:	
Address:	City:	State:	ZIP:
GENDER: M F	DATE OF BIRTH: / /	SS#	

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Integrative Insomnia and Sleep Health Center, Inc., a California Corporation. I understand that I am financially responsible for all charges, whether or not they are covered by insurance and I may be charged a fee for missed or cancelled appointments if I do not give one business day notice. I hereby authorize this healthcare provider to release all information, including psychiatric and chemical dependency, history to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I understand that I am also responsible for advising Integrative Insomnia and Sleep Health Center of any changes to my insurance, address and phone numbers on or before the date of service. If my insurance does not cover any office visit, any diagnostic testing, and/or treatment, I understand that I am responsible for full payment of services rendered and will make prompt, satisfactory arrangements to settle my account. I certify that I have read and understand the above assignment of benefits and financial agreement.

Signature:____Date:_____________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ____ hereby authorize Integrative Insomnia and Sleep Health Center to receive my medical records as needed for medical evaluation.

In addition, I authorize Integrative Insomnia and Sleep Health Center to release my medical records, to the extent necessary, to a healthcare entity involved in my treatment

A healthcare entity may include another healthcare provider whom I am seeing or plan to see regarding my health, or a company, which provides appropriate medical treatment devices.

Patient's Printed Name: ____

Date of Birth:____

Date: From (today)_________________to Date (maximum one year)____________

Signature: ____

(If signed by other than patient) Name: __________________________________
Relationship: ____

Authorization to Communicate with Someone Other Than Yourself (i.e. relatives or friends)

Do you authorize us to communicate with another person(s) about your protected health information on your behalf? Please circle Yes No

Name:__________________________________ Relationship:_______________

Name:__________________________________ Relationship:_______________

This information is limited to (please circle): All information, Appointment Scheduling Only, or Please Specify:____
____

Starting Date (today)______________________ to Ending Date (maximum one year):_______________

Patient Signature:_______________________________________

CANCELLATION AND RESCHEDULING POLICY

If you need to cancel or reschedule your appointment, we request notice **AT LEAST 24 BUSINESS HOURS IN ADVANCE OF THE APPOINTMENT.** We reserve dedicated time specifically for your appointment, and request the notice in order to reallocate the time to help others. Failure to receive notice at least 24 business hours in advance may result in a charge of $25 for a follow up appointment and $75 for a new appointment.

I have read and understand the above policy.

Signed: ____

Date: ____

NOTICE OF PRIVACY PRACTICES (NPP)

Effective February 20,2012

The privacy of your protected health information is important to us. Please review this notice carefully, as it describes how your medical information is used and maintained by our organization and by our offices and work staff. It also describes your rights as to the information and how you can get access to it.

PLEASE CONTACT US WITH ANY QUESTIONS THAT YOU MAY HAVE REGARDING THIS NOTICE. WE URGE YOU TO REVIEW THIS NOTICE CAREFULLY AND ASK ANY QUESTIONS THAT YOU MAY HAVE ABOUT THE USE OR SHARING OF YOUR PROTECTED HEALTH INFORMATION.

Your Protected Health Information

Whenever you receive or request durable medical equipment or services from our organization through a prescription, we receive and create personal medical information about you and about the equipment or services you receive or request. We need this information in order to provide equipment or services to you and to comply with certain legal requirements. It is our goal to make sure that the personal medical information we receive or create about you is kept strictly private. It is necessary, however, to use it or share this information with others from time, but only under proper circumstances.

This Notice describes how we may properly use and share your medical information, which we will refer to as "protected health information." This Notice also describes your rights to access and control your protected health information. In reviewing the Notice, it may appear that your medical information is used or shared in many ways. But, this is a comprehensive list and certain events may never occur or might happen only once or a few times. For the most part, your medical information is used or shared only in connection with the equipment or services that we provide you.

We have an obligation to make sure that we give a copy of this Notice and follow its terms. This Notice applies to protected health information generated at each of our offices.

When we refer to "we" or "us" in this Notice, we mean our organization and our staff, and also refer to each of our offices and the technicians and other work force staff who contribute to your care. We will provide you with a list of the persons and locations covered by this Notice upon your request.

HOW WE USE OR SHARE PROTECTED HEALTH INFORMATION

Typical Uses and Sharing:

Your protected health information may be used or disclosed for theses typical situations without your prior authorization.

Treatment: We will use and disclose your protected health information in order to provide services to assist physicians or other health care providers assess you medical condition or treat you. We may disclose your protected health information to your primary care or family physician, to an Integrative Insomnia and Sleep Health Center clinician, to a specialist, or to another clinic, physician, hospital or other health care provider who requests this information in connection with your care and treatment. Your shared protected health information may include information that we receive from Integrative Insomnia and Sleep Health Center or from other physicians or health care providers. For example, we may have received and maintain an order from your physician and sleep study test results, which we may need in order to determine the durable medical equipment and services that you require. We may in turn disclose information regarding your durable medical equipment and services and other protected health information in our possession to your personal physician or other health care provider who is treating you.

Payment: We may use and disclose your protected health information in order to obtain payment for our services or to allow insurance companies, health plans, government agencies and managed care companies to process claims for services rendered by us to you. For example, we may need to give your health plan information about your health condition in order to obtain authorization for you to receive durable medical equipment or services.

Health Care Operations: We will use and disclose your protected health information in order to revaluate the quality and appropriateness of care provided by our physicians and health care professionals. We may need to use and disclose protected health information in connection with licensing, payment certifications and other status. We may use and disclose your protected health information in our organization's day to day operations to enable it to operate smoothly, efficiently and in compliance with applicable laws. As examples, your protected health information may be used in routine activities such as calling you to remind you of a scheduled appointment. We may also consider your information in planning as well as use your information to assist in training.

Employer/Plan Sponsors: We may disclose your protected health information to your employer or other group health plan sponsor in connection with administration of the health plan and/or payment for services. Information to your employer that falls outside of these purposes may require your prior written authorization.

Healthcare Information: We may use your protect health information to contact you from time to time with information about services that we offer or coordinate your care with other health care providers or with treatment alternatives. If you do not wish to receive this type of information, you may opt out of receiving this information by contacting us. However, even if you elect not to receive this information, you may still continue to receive information made available to patients generally, such as newsletters or updates.

You, Family and Close Friends: We may disclose your protected health information to you unless there is information in your file that we are not legally authorized to release to you, such as information related to psychotherapy. We may also disclose information to a family member, friend or other person if you are incapacitated such as in a medical emergency or disaster relief. We will disclose this information only to the extent necessary to help with your health care or with payment for your health care.

Public Health and Safety Research: We may use and disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may use or disclose your protected health information for limited research purposes.

Outside Service: We may also need to share your protected health information with outside individuals or companies that perform services for us. For example, if we use a vendor or contractor to perform such things as billing or practice management, they may need access to your protected health information. We ask that any outside service or vendor safeguard the privacy of your protected health information in their possession. We do not intend to share your information with any outside service that does not need your information to do this job such as maintenance crews.

Unintended Disclosure: We will try our best to prevent this but it is possible that others may learn of protected health information because they hear or see information that is not meant for them. For example, another patient might overhear a conversation between you and a durable medical equipment or service technician. We use reasonable efforts to try to prevent any such disclosure from occurring.

Authorized Use or Disclosure:

If you specifically authorized us to do so in writing we will share your protected health information to persons who are not involved with your care and not included in one of the categories listed above. This might include, for example, your employer (for reasons other than related to health plan administration) a life insurance company or a distant relative. Our privacy Officer or our staff will provide the necessary form for this authorization. You may cancel this authorization at any time.

Unusual Uses or Disclosures
Among the unusual uses or disclosures that may occur without your prior authorization are the following:

Required by Law: We will use or disclose your protected health information when we are required to do so by law. For example, we would be required to share such information with a government agency in connection with an audit or investigation or if we are required by law to report a health condition to a federal state or local agency.
Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena discovery request or other lawful process.
Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of suspect fugitive material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.
Military and Nations Security: we may disclose to Military authorities the protected health information of Armed Forces personnel. We may disclose to authorized federal officials protected health information required for lawful intelligence, counterintelligence and other national security activities.

INDIVIDUAL RIGHTS
You have rights with respect to your protected health information. If you have any questions about theses rights or want to exercise any of these rights please contact us to assist you.

Inspect and Copy Your Records: Except for certain mental health information, if any is included in your records, you may inspect and receive a copy of some or all of your protected health information. Your request must be in writing and we will charge a fee to provide a copy. We also will need a reasonable time to provide the copy, as permitted by law.
Request Restrictions: You may request restrictions on how your protected health information is issued or disclosed. You can request in writing that we place additional restrictions on the use or disclosure of your protected health information. We are not required to agree to these additional restrictions but if we elect to do so, we will abide by the agreement (except in an emergency).
Receive Confidential Communications: You can specify how and where we should send protected health information. For example, you may want all such information in writing rather than left as a voice message, or you may request that we send all correspondence for you to your work address. We will accommodate reasonable requests.
Amend Your Record: If you feel that health information we have about you is incorrect or incomplete you may ask us to amend or change the information. However we might not agree to your request. There are various reasons why we may deny your request for an amendment. If you submit a request for amendment we will provide you with more information about the process. We will notify you in writing regarding our action on your request.
Log of Unusual Events: You have the right to request a log of unusual events that resulted in our sharing protected health information. We are required to maintain events on this list for six years. The log will only list those disclosures that you have not authorized and which were not related to treatment, payment or our operations. This log might include for example the sharing of information with the police or with a government agency, which was necessary without your permission.

Copy of This Notice: You may receive upon request, a paper copy of this notice at any time.

OUR RIGHT TO CHANGE NOTICE
We reserve the right to change his notice. We may modify or change our privacy practices from time to time particularly as new laws and regulations become effective. Any changes will be effective for all the protected health information that we maintain even information in existence before the change. If we materially modify our privacy practices we will provide you with a new notice advising you of these changes when you next obtain services from us.

COMPLAINTS
If you believe that your protected health information was not handled properly or feel that we have not allowed you to exercise your rights you may contact Region IX of the office of Civil Rights of the Department of Health and Human Services at (415) 437-8310 voice, (415) 437-8329 fax or at email address OCRComplaint@hhs.gov. We respect your rights and will not retaliate against you or stop your care if you feel it necessary to file a complaint.

PLEASE SIGN THE ATTACHED ACKNOWLEDGEMENT CONFIRMING THAT YOU HAVE RECEIVED A COPY OF THIS NOTICE.

Acknowledgement of Receipt of Notice of Privacy Practices (NPP)

I hereby acknowledge that I have been provided with a copy of Integrative Insomnia and Sleep Health Center's Notice of Privacy Practices (NPP)

Signature: ______________________________ Date: ____________________

LIFETIME ASSIGNMENT OF INSURANCE BENEFITS
AND
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Medicare, Private Insurance and Medicaid Beneficiaries

Name: ____

I request that payment of authorized Medicare, Medicaid, or other insurance benefits be made on my behalf to Integrative Insomnia and Sleep Health Center Inc. for any services furnished to me by my physician or supplier.

I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services (CMS) or any agents and carriers, as well as Integrative Insomnia and Sleep Health Center Inc. any information or documentation needed to determine these benefits or the benefits payable for related services, now or in the future. I authorize Integrative Insomnia and Sleep Health Center, Inc. to release any information required to process any and all claims for reimbursement on my behalf. I permit a copy of this authorization to be used in place of the original.

I understand I am financially responsible for any charges not paid by said insurance. I agree to pay co-payments and/or deductibles designated by my insurance company or health plans, as well as non-covered services.

Services provided:

- Polysmnography / Home Sleep Test / Split Night / MSLT/ Oximetry / Actigraphy
- Consultation / Office Visit
  Other: ________________________

Notice to Medicare Beneficiary

Medicare regulations require that we notify you when services provided or to be provided may not be covered by Medicare. Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (a) (1) of the Social Security Act. If Medicare determines that a particular service, although it would otherwise be covered, is "Not Reasonable and Necessary" under the Medicare program standards, Medicare will deny payment for the services.

It is possible that Medicare may deny the services provide to you by Integrative Insomnia and Sleep Health Center Inc., for the following reason:
( ) Non-Covered charges
( ) Same or similar equipment or service billed
( ) Procedure / Service not a covered Benefit with Diagnosis code billed
( ) Service not covered because the patient was enrolled in a SNF / Hospice.
( ) Medicare will not pay for Procedure or Service(s) that are deemed Not Medically Necessary.

Name:____

Signature: ____

Date:____