TOTAL HEALTH SLEEP SOLUTIONS, INC.

87 S. McLean Blvd., Suite B – South Elgin, IL 60177 – P: 847.888.8311 - F: 847.429.9334

Health Insurance Portability Accountability Act (HIPAA)

Patient Name _____ DOB_____

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordinator or management of your health care with a third party. For example, we would disclose your protected health information to a physician to whom you have been referred to ensure that the physician has all the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: a Require By Law, Public Health issues as required by law, communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, or criminal, or administrative action of proceeding, and protected health information that is subject to law that prohibited access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to who you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or physicians practice has taken an action in the reliance on the use or disclosure indicated in the authorization.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy or, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office number.

You may request a copy of this notice at any time.

Your signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature _____Date _____

Emergency Action Plan

In the event of an emergency where we need to cancel or reschedule your existing appointment, a member of our staff will contact you via phone at the earliest opportunity. We will do our best to notify you as soon as possible and accommodate your schedule.

Signature _____Date _____

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Authorization to Release Protected Health Information to Family Members & Physicians

Per HIPAA regulations, we are no longer allowed to release patient information to anyone other than the patient, legal guardian or authorized persons, unless specific written authorization is given to our office. In the space below, list any family members or physicians that you give your permission for the doctor or team member to discuss your medical information. This permission can be rescinded at any time per the patient's verbal or written request. This authorization is to facilitate continuity of care and you are entitled to receive a copy of this agreement.

Family Member / Physician **Relationship to Patient** **Phone**

_____

_____

_____

I authorize (check one)

- All medical information, including but not limited to, records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, treatment records, diagnosis and prognosis records, any and all clinical notes and any other non-medical information in my file.
- Only the following types of information: _____

Authorization to Receive Confidential Communications of Protected Health Information

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Health Information

Please select the best option below for the physician or staff to speak with you ***regarding medical issues***.

- HOME _____ OK to Leave a Message: YES NO

  Persons at home number authorized to take message: _____
- CELL _____ OK to Leave a Message: YES NO
- WORK _____ OK to Leave a Message: YES NO
- EMAIL _____ OK to Leave a Message: YES NO

For the message left, please authorize the type of information you would like left:

- ANY AND ALL DETAILED INFORMATION (ie. Test Results, Diagnosis, Insurance Information, etc.)
- A BRIEF DESCRIPTION WITH A REQUEST TO CALL BACK REFERENCING THE CALLER'S NAME, LOCATION AND OFFICE #
- LEAVE ONLY A REQUEST TO CALL BACK, REFERENCING THE CALLER'S NAME, LOCATION AND OFFICE #

By signing below, I acknowledge that I have read this statement and agree to the contents.

Signature _____Date _____