SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC
Murfreesboro 1505 Williams Drive Ste 200, Murfreesboro (615) 893-4896
Murfreesboro Medical Clinic 1272 Garrison Drive, Ste 301, Murfreesboro (615) 893-4896
Cool Springs 3326 Aspen Grove Dr, Ste 260, Franklin (615)893-4896

PATIENT Name _____

Birthdate _____ Social Security Number _____ Sex: M F

Address _____ City _____ St _____ Zip _____

Home Phone _____Cell Phone _____ **Marital Status:** M S D W

E-mail address: _____

Language: English, Russian, Spanish, Indian (includes Hindi & Tamil), or Other.

Race: American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, White, Hispanic, Other Race, Other Pacific Islander, Unreported/Refused to Report

Ethnicity: Hispanic or Latino ___ Yes ___No ___ Refused to Report

Referred by: _____ **Primary Care Doctor:** _____

Pharmacy: _____ **Pharmacy Address:** _____

PRIMARY INSURANCE _____ **Policy/ID** _____

Name (IF OTHER THAN PATIENT) _____ Birthdate _____

SECONDARY INSURANCE _____ **Policy/ID** _____

Name (IF OTHER THAN PATIENT) _____ Birthdate _____

EMERGENCY CONTACT: Name _____ Phone _____ Relationship _____

APPOINTMENT REMINDERS

How would you like to be contacted regarding your upcoming appointments? (check all that apply)

____ Home Phone ____ Cell Phone ____ E-mail ____Text Message

ELECTRONIC MEDICAL RECORDS ONLINE ACCESS

SCMT has the ability to provide access to your Electronic Medical Record to you via HIPAA compliant website.

Would you like access to your Electronic Medical Record online? ____ Yes ____ No

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I have received a copy of Sleep Centers of Middle Tennessee, PLLC's Notice of Privacy Practices.

Signature: _____ Date: _____

RELEASE: I, the above named patient, authorize Sleep Centers of Middle Tennessee, PLLC or any of its agents, to release any and all of my medical information and appointment information to the following individuals who are involved in my treatment:

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BY SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Patient Name_____ Date of Birth _____

I hereby authorize the internal use or disclosure of any and all of my protected health information by Sleep Centers of Middle Tennessee, PLLC (the "Practice") for marketing and advertising purposes, including but not limited to targeted advertisements and promotions of products that the Practice believes may be useful or desirable to me.

I understand that this authorization is voluntary and that I may refuse to sign it.

I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization, if any, may be found in my provider's Notice of Privacy Practices.

I understand that, if my information is used by or disclosed to a third-party that is not a health care provider or a health plan, the information used or disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient.

I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study.

This authorization will expire if and when I end my provider-patient relationship with the Practice.

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:_____

FINANCIAL POLICY

I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to Sleep Centers of Middle Tennessee. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents.

Signature: _____ Date: _____

We are happy that you have chosen Sleep Centers of Middle Tennessee to provide your healthcare needs. We are committed to providing the best care and service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be glad to answer any questions you may have.

We participate in most insurance plans, but due to continuing changes within the insurance industry, we cannot guarantee that your services will be covered. However, we will work with you and your insurance company to come to an agreement if we are not contracted with your carrier. As most insurance companies do not require pre-certification for our services, it is the patient's responsibility to check to see if predetermination is required. Our staff will provide pertinent information upon request.

We will file all claims to the patient's insurance company(s) upon receipt of all required information and releases. You will not be sent a statement until after we have received payment or denial from the insurance. All statements are due and payable upon receipt. Insurance payment authorizations are included in your paperwork. Should you refuse to sign the authorization to have your insurance benefits paid to us, you will be responsible for paying the total of your charges at the time of service. It is the patient's responsibility to ensure that Sleep Centers of Middle Tennessee is a contracted provider for his/her insurance.

_____ initials I understand that the contract between me and the insurance company provides that all co-payments are due and payable at the time of service and that service can be denied if I am not prepared to pay my co-pay per the contract between my insurance company and the provider. (discretion on a case by case basis)

Unless prior arrangements have been made, those who are uninsured are expected to pay at the time of the service. We accept MasterCard and Visa for your convenience. I have read, understand, and agree to abide by the above policies.

Printed Name_____ Date of Birth_____

Signature _____ Date_____

EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

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 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

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

SCORE: _____

MEDICATION (NAMES ONLY)		
PAST MEDICAL HISTORY		
ALLERGIES		
PAST SURGICAL HISTORY		

FAMILY HISTORY				
MOTHER		**FATHER**		**OTHER**

Revised 12-2016

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BY SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Patient Name_____ Date of Birth _____

Person or Organization Receiving the Information:

	Name	Address	City, State, Zip
1.			
2.			

Specific Description of the Information to be disclosed:

☐ All Medical Records

☐ Other (Specify):_____

The Purpose of this disclosure is:_____

This authorization will expire on: Date: NONE OR when the following occurs: _____

(Note: If no expiration is indicated above, this authorization will expire one year from the date of signing, as written below.)

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization, if any, may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

_____ _____

Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:_____

Sleep Centers of Middle Tennessee, PLLC

Notice of Privacy Practices

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA" or "Act"), revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health care operations without your authorization, unless otherwise prohibited by law.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum information necessary to friends or family members involved in your care, unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum information necessary with friends or family members involved in payment for your care, unless you request otherwise.
- Health care operations: We are allowed to use or disclose the minimum necessary amount of your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, and for other operational needs.
- We may also disclose information as required by law; to fulfill certain public health purposes; if we believe you have been a victim of abuse, neglect, or domestic violence; for certain health care oversight activities; for judicial, administrative, and law enforcement proceedings; to coroners and medical examiners; for organ or tissue donation purposes; for research; to avert a serious threat to health or safety; for certain specialized government functions; and for workers' compensation.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your protected health information for marketing, the sale of your protected health information, and any use or disclosure not described in this Notice of Privacy Practices. You will receive a copy of any authorization that you sign. You may revoke any authorization in a signed writing, and we will honor that revocation beginning with the date we receive it, but your revocation will not apply to any information that was disclosed prior to your revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 10 days of your request. We will provide your records in the format you request, whether electronic or hard copy, if we can reasonably produce the records in your requested format. We may charge you our reasonable cost for making and providing the records, not to exceed $20.00 for a record of 5 or fewer pages, plus 50 cents per page after that and the cost of

mailing. If your request is denied, you may request a review of this denial by a licensed health care provider.

- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are generally not required to agree to these requests, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions, if necessary, to fulfill treatment and payment.
- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations, even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of certain disclosures of your protected health information, not including disclosures to you; disclosures pursuant to a valid authorization; disclosures for treatment, payment, and health care operations; and certain other disclosures permitted or required by law. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice upon request, electronic or paper or both.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below. You also have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Lisa Roberson
Mail: 1505 Williams Drive Ste 200, Murfreesboro, TN 37129
Phone number: 615-893-4896; Fax number: 615-893-4821
Email: lroberson@sleepcenterinfo.com

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which originally became effective September, 2013 and became effective in its current form October 2015. We reserve the right to change the terms of this Notice of Privacy Practices and to make the new terms effective for all protected health information that we maintain. We will post the revised Notice of Privacy Practices on our website and provide you with a paper copy upon request.