SLEEP CENTERS OF MIDDLE TENNESSEE, PLLC

Murfreesboro 1508 Carl Adams Drive Ste 200, Murfreesboro, TN 37129 (615) 893-4896
Murfreesboro Medical Clinic 1272 Garrison Drive, Ste 301, Murfreesboro, TN 37129 (615) 893-4896
Cool Springs 3326 Aspen Grove Dr, Ste 260, Franklin, TN 37067 (615) 893-4896
Clarksville 1750 Memorial Drive, Clarksville, TN 37043 (931) 614-6324

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:	____________

Questions © M. W. Johns 1990-1997

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

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

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:____

HIPAA Notice Of Privacy Practices

Sleep Centers of Middle Tennessee, PLLC

Effective Date: June 1, 2019

We at Sleep Centers of Middle Tennessee, PLLC ("we," "us" or "our") take the privacy of your personal health information (or **PHI**) seriously. Pursuant to our obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are providing you with this Notice of Privacy Practices.

Overview

This notice describes how we may use or disclose your health information and how you can get access to your individually identifiable health information. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. We must follow the terms of this Notice as in effect at the time. PLEASE READ IT CAREFULLY.

We are required by law to maintain the privacy of your PHI, provide you with notice of our legal duties and privacy practices with respect to PHI, and notify you if your PHI is affected in a breach of unsecured PHI.

Our Use and Disclosure of PHI

We use and disclose your health information for normal health care business activities that fall in the categories of treatment, payment and healthcare operations. Some examples of these activities, but not all, are set out below.

Treatment – We keep a record of the health information you provide us for treatment purposes. These records may include your test results, diagnoses, medications, your response to medications or other therapies. We may disclose this information to other health care providers, such as outside doctors, nurses, or laboratories, as part of your ongoing healthcare needs.

Payment – We document the services and supplies you receive when we provide care to you so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require prior approval by your health plan.

Healthcare Operations – We may use your health information to improve the services we provide, to train staff, for business management, quality assessment and improvement, and for customer service. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. In other cases we may communicate with individuals involved in your care or payment for that care, such as friends and family and send appointment reminders.

Other Uses or Disclosures

We may also use your health information to:

- Comply with federal, state or local laws that require us to disclose your PHI
- Assist in public health activities such as tracking diseases or medical devices.
- Inform authorities to protect victims of abuse or neglect.
- Comply with federal and state health oversight activities such as fraud investigations.
- Respond to law enforcement officials or to judicial orders, subpoenas or other process.
- Inform coroners, medical examiners and funeral directors of information necessary for them to fulfill their duties.
- Facilitate organ or tissue donations.
- Conduct medical research, but only after following internal review protocols that consider the privacy of your information.
- To help prevent serious threats to health or safety.
- Assist in specialized government functions such as national security, intelligence and protective services.
- Inform military and veteran authorities if you are an armed forces member (active or reserve).
- Inform workers' compensation carriers or your employer if you are injured at work.
- Recommend treatment alternatives or tell you about health-related products and services.
- Provide information to other third parties with whom we do business, such as a record storage provider. We require third parties in such situation to provide us with assurances that they will safeguard your information.
- Disclose your information to family, friends and other persons who are involved in your medical care. You have the right to object to the sharing of this information. Disclosures may only occur without authorization in instances of emergency or incapacity to effect treatment or care.

All other uses and disclosures, not previously described, may only be done with your written authorization. We will also obtain your authorization before we use or disclose your health information for marketing purposes or before we would sell your information. You may revoke your authorization at any time; however, this will not affect prior uses and disclosures. In some cases state law may require that we apply extra protections to some of your health information.

Our Responsibilities Regarding Your Health Information

We are required by law to:

- Maintain the privacy of your health information.
- Provide this Notice of our duties and privacy practices.
- Abide by the terms of the Notice currently in effect.
- Tell you if there has been a breach that compromises your health information.

Your Legal Rights Respecting Your PHI

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Receive Copies of Your Records. In most cases, you have the right to inspect or receive copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

- Right to Request a Correction or Update of Your Records. You may ask us to amend information you feel to be incorrect or add missing information to your records. You must make the request in writing and provide a reason for your request. We may deny your request in certain limited circumstances.

- Right to Get a List of Disclosures. You have the right to ask us for a list of disclosures or access report made within the last three years. You must make the request in writing. The list will not include information provided directly to you or your family, or information that was sent with your authorization.

- Right to Request Limits on Uses or Disclosures of PHI. You have the right to ask that we limit how we use or disclose your information. You must make the request in writing to us and tell us what information you want to limit and to whom you want the limits to apply. We are not required to agree to the restriction, unless the restriction is for disclosures to a health plan for carrying out payment or health care operations that are not otherwise required by law, and the PHI pertains solely to a health care item or service for which you personally, and not your plan, have paid in full. You can request that the restrictions be terminated in writing or verbally.

- Right to Revoke Permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing to us. This will not affect information that has already been shared.

- Right to Choose How We Communicate with You. You have the right to request that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You must make this request in writing. You do not have to explain the basis for your request.

- Right to Get a Paper Copy of this Notice. You have the right to ask for a paper copy of this notice at any time.

We may ask that you make some of these requests in writing.

Revisions to Our Notice of Privacy Practices

We reserve the right to change our privacy practices and to make the new practices effective for all the information we maintain. We will post revised notices on this website and mobile application.

Compliant Procedure

If you believe that the privacy of your PHI has been compromised by us, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary.

To file a complaint with us or receive more information contact:

Sleep Centers of Middle Tennessee, PLLC
ATTN: Privacy Officer
Phone: Janice Henderson
E-Mail: jhenderson@sleepcenterinfo.com

To file a complaint with the Secretary of Health and Human Services:

US Secretary of Health and Human Services
200 Independence Ave., S.E.,
Washington, D.C. 20201
1-800-537-7697
For an on-line complaint, sign onto:
https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf.

If you have any questions regarding this notice or our health information privacy policies, you may contact our Privacy Officer at 615-893-4896.