Dedicated Sleep

FLORIDA DENTAL SLEEP DISORDERS

Dedicated Sleep, LLC
Notice of Privacy Practice
Effective January 1, 2018

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.

Questions? Please contact our Privacy Office at the address/ phone number at the end of this notice.

Who will follow this notice?

We provide health care to patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All contracted service partners for sleep and DME services.
- Any healthcare professional authorized to enter information into your chart, including practicing physicians and other credentialed individuals that participate with us in providing care and services.
- Any business associate or partner with whom we share health information.

Our Pledge to You:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in order to provide quality care and to comply with legal requirements of the Health Insurance Portability and Accountability Act of 1996 (HI PAA). This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the current notice.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If there is a significant change in our policies, we will change our notice and post the new version in areas of the facilities generally accessible by patients and their families. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you with your consent or with the consent of others who are legally permitted to consent on your behalf for treatment (e.g., sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (e.g., sending billing information to your insurance company or Medicare); and to support health care operations (e.g., comparing patient data to improve treatment methods.)
- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, birth, death, abuse or neglect and domestic reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and other emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, e.g., regarding inmates in their custody, or in response to valid judicial or administrative orders.

- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you,
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, you or your personal representative have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after your date of service. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our Privacy Office listed below:

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office at:

Address: Privacy Office C/O Dedicated Sleep 21260 S. Springwater Road, Estacada Oregon 97023

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

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FLORIDA DENTAL
SLEEP DISORDERS

Acknowledgement of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement*

I have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

Office use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

D Individual refused to sign

D Communications barriers prohibited obtaining the acknowledgement

D An emergency situation prevented us from obtaining acknowledgement

D Other (Please Specify)

_____
_____
_____

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FLORIDA DENTAL
SLEEP DISORDERS

Informed Patient Consent

Patient Name: ---------- DOB: ----------

Welcome! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

CONFIDENTIALITY AND PRIVACY NOTICE:

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

IN CASE OF EMERGENCY, PLEASE CONTACT DEDICATED SLEEP AT (800) 279-3104

_____ _____

Patient Date

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FLORIDA DENTAL
SLEEP DISORDERS

21260 S. Springwater Rd | Estacada, OR 97023
Phone: 800-279-3104 | Fax: 949-798-6979 | dentalinfo@dedicatedsleep.net | dedicatedsleep.net

Medical Records Release Form

Patient's Name: ----------

Date of Birth: ---------

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Dedicated Sleep
21260 S. Springwater Rd
Estacada, OR 97023

Patient Signature: ----------

Date signed: