SLEEP HISTORY

NAME: _____ **DOB:**_____ **REFERRING DR:**_____

Last First MI

Have you had a sleep study in the past? If so, what was the outcome of the sleep study?

Are you currently using CPAP, if so what pressure?

What is your normal sleep schedule?

What is your height and weight?

Are you able to sleep on your back?

Do you have heart disease?

Have you had a stroke?

Do you have neuromuscular disease? (e.g. Parkinson's disease, myotonic dystrophy, ALS, MS)

Do you have pulmonary disease?

Do you use Supplemental Oxygen?

Have you been diagnosed with Narcolepsy?

Have you experienced Sleep Paralysis (inability to speak or to move the limbs, trunk, and head) upon falling or waking up from sleep?

Do you experience hallucinations prior to sleep onset, on awakening during the night, or in the morning?

Do you have Restless Leg Syndrome?

Are there complaints of your arms or legs moving during sleep?

Have you experienced, or partner witnessed, recent episodes of sleepwalking?

Have you experienced, or partner witnessed, episodes of sleep talking or shouting?

Have you experienced, or your partner witnessed, dream enactments (e.g. talking, laughing, shouting, grabbing, arm flailing, kicking)?

Do you have recurrent nightmares that cause you to wake up and be unable to fall back asleep?

Have you experienced episodes of crying or screaming and waking up in fear?

Is there a history of regularly occurring groaning during sleep?

Have you experienced sudden loud noises or sense of explosion in the head upon falling asleep?

Do you have recurrent episodes of involuntary eating and drinking during sleep?

Have you been diagnosed with any other sleep disorder?

EPWORTH SLEEPINESS: On a scale of 0-3, 0=never, 1=slight, 2=moderate, 3= high, what chance would you doze off in the following situations.

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (e.g. theater or a meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

In a car while stopped for a few minutes in traffic _____

Sitting quietly after lunch without alcohol _____

TOTAL: _____

STOP-BANG SURVEY

Snore: Have you been told that you snore?

Tired: Are you often tired during the day?

Obstruction: Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?

Pressure: Do you have high blood pressure or take medication to control high blood pressure?

BMI: Is your body mass index greater than 35?

Age: Are you 50 years old or older?

Neck: Are you a male with a neck circumference > 17 inches, or a female with a neck circumference > 16 inches?

Gender: Are you a male?

TOTAL questions answered YES. : _____

SCHEDULING ASSESMENT FORM

Do you have any nutritional needs during the night?

Any known allergies? If yes, please describe.

Do you have and/or being treated for any active infection? If yes, please describe.

Will arrangements need to be made for another person or caretaker to stay overnight at the facility?

Do you use a dental device? If so, what for.

Do you use a wheelchair?

Do you speak English? If no, will you need a translator present for the sleep study?

Do you have a visual or hearing impairment? If so, please explain.

INSOMNIA SEVERITY INDEX; On a scale of 0-4 (0=none, 1=mild, 2=moderate, 3=severe, 4=very severe) list your current answer.

1. Difficulty Falling Asleep

2. Difficulty Staying Asleep

3. Problem waking up too early.

For question 4 (0=very satisfied, 1=satisfied, 2=moderately satisfied, 3=dissatisfied, 4=very dissatisfied) **4.** How satisfied/dissatisfied are you with your current sleep pattern?

For questions 5-6 (0=not at all noticeable, 1=a little, 2=somewhat, 3=much, 4=very much noticeable) **5.** How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?

6. How worried/distressed are you about your current sleep problem?

For question 7 (0=not at all interfering, 1=a little, 2=somewhat, 3=much, 4=very much interfering) **7.** To what extend to you consider your sleep problem to interfere with your daily functioning(e.g. daytime fatigue, mood, memory, concentration)

TOTAL SCORE:_____

FATIGUE SEVERITY SCALE; On a scale of 1-7 (1=strong disagreement with the statement, whereas 7=strong agreement) During the past week:

1. My motivation is lower when I am fatigued.

2. Exercise brings on my fatigue.

3. I am easily fatigued.

4. Fatigue interferes with my physical functioning.

5. Fatigue causes frequent problems for me.

6. My fatigue prevents sustained physical functioning.

7. Fatigue interferes with carrying out certain duties and responsibilities.

8. Fatigue is among my three most disabling symptoms.

9. Fatigue interferes with my work, family or social life.

TOTAL SCORE: _____

Personal History

What is your chief complaint?

Do you have constitutional problems such as fever, weight loss, etc

Have you ever had or been diagnosed with Headaches / Migraines?

Have you ever had or been diagnosed with Epilepsy/Seizures?

Have you ever had or been diagnosed with Depression / Anxiety?

Have you ever had or been diagnosed with Heart disease / Stroke or Circulation Problems?

Have you ever had or been diagnosed with Dizziness / Fainting / Weakness?

Have you ever had or been diagnosed with High / Low Blood Pressure?

Have you ever had or been diagnosed with Anemia?

Have you ever had or been diagnosed with Arthritis?

Have you ever had or been diagnosed with Diabetes?

Have you ever had or been diagnosed with Cancer?

Have you ever had or been diagnosed with Gout?

Have you ever had any surgeries? If so, please list.

Have you ever smoked or do you currently smoke?

Do you drink alcohol?

Do you drink caffeinated beverages?

Do you exercise outside of normal daily activities?

Family History

Do you have family history of Heart Disease or Stroke?

Do you have family history of High Blood Pressure?

Do you have family history of Cancer?

Do you have family history of Diabetes?

Do you have family history of Epilepsy?

Do you have family history of Bleeding Disorder?

Do you have family history of Kidney Disease?

Do you have family history of Arthritis?

Do you have family history of Mental Illness?

Do you have family history of Osteoporosis?

Do you have family history of Thyroid Disease?

Current Medication List

List all medications (prescribed or over the counter/herbal supplements) that you are currently taking:

Medication	Start Date	Dose/Frequency	Prescribing Physician ❑	Comments
			❑	
			❑	

List any allergies you have to medications:

Previous Testing

Have you had any of these tests?
(Check all that apply)

	Date Performed	Where Performed	Result
❑ MRI			❑ Normal ❑ Abnormal
❑ CT Scan			❑ Normal ❑ Abnormal
❑ EEG (Brain Wave Recording)			❑ Normal ❑ Abnormal
❑ EP (Evoked Potential) Study			Normal ❑ Abnormal
❑ EMG and Nerve Conductions			Normal ❑ Abnormal
❑ Cerebral Arteriogram			Normal ❑ Abnormal
❑ Carotid Doppler			Normal ❑ Abnormal
❑ Echocardiogram			Normal ❑ Abnormal
❑ LP (Spinal Tap)			Normal ❑ Abnormal
❑ Myelogram			Normal ❑ Abnormal
❑ Blood Tests (Specify)			Normal ❑ Abnormal
❑ Bone Density			Normal ❑ Abnormal

Patient information

Last name:

First name:

Middle initial:

Date of birth:

Sex:

Social security:

Nickname:

Communication:

Language:

Race:

Ethnicity:

Address & contact information

Street1:

Street2:

Zip code:

City:

State:

Home phone:

Cell phone:

Work phone:

Email:

Emergency contact:

Emergency phone:

Primary Care Provider

Name: _____

Phone#_____

Referring Provider

Name: _____

Phone#_____

Preferred Pharmacy:

Name: _____

Address: _____

City:_____ State:_____ ZIP:_____

Primary insurance information

Insurance:

Policy#:

Group#:

Plan name:

Subscriber:

Active Date:

Secondary insurance information

Insurance:

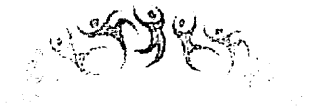
Policy#:

Group#:

Plan name:

Subscriber:

Active Date:



4 BETTER SLEEP
CENTERS

Modified F.O.S.Q.

Q1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q2. Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q7. Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Q10. Has your mood been affected because you are sleepy or tired?

1. Yes, extreme 2. Yes, moderate 3. Yes, a little 4. No

Score:	**Patient Name:**	**D.O.B:**	**Date:**

HIPAA Electronic Communication Client Consent

IMPORTANT—PLEASE READ AND SIGN

General Information

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for protected health information (PHI)
- HIPPA information is available on the U.S. Department of Health and Human Services website at hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers- to-use-email-to-discuss-health-issues-with-patients/index.html
- Information stored on computers is encrypted; hard copies of information are stored under double lock
- Most popular email services (e.g., Hotmail®, Gmail®, Yahoo®, etc.) do not utilize encrypted email
- Text messages sent via standard SMS/apple iMessage are not encrypted or secured
- Facebook messenger does not utilize encrypted messaging
- Skype and Facetime are not secured lines of communication

When we send you an email, or you send an email to us, the information sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.

In addition, once an email is received by you, someone may be able to access your email account and read it. This also applies to text messages, Facebook messages, and other forms of social media messaging.

Given the above, please note that:

- **Email and texting are popular and convenient ways to communicate. In their latest modification to the HIPAA act, the federal government provided guidance on electronic communication and HIPAA. Current Federal guidelines state that if a patient has been made aware of the risks of unencrypted communication, and that same patient provides consent to receive health information via electronic communication, then a health entity may send that patient personal medical information via unencrypted electronic means.**

Now that you have been informed about the above information, please review the following and sign the options you prefer.

Email

OPTION 1—ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to Somnologix, Ltd d/b/a 4 BETTER SLEEP and P. Terrence Moore, MD to send me personal health information via unencrypted email.

Signature_____

Printed name _____

Date_____

Print email address _____

OPTION 2—DO NOT ALLOW UNENCRYPTED EMAIL
I do not wish to receive personal health information via email

Signature _____

Printed name _____

Date_____

Print email address _____

Text Messaging

OPTION 1—ALLOW UNENCRYPTED TEXT MESSAGING
I understand the risks of unencrypted text and do hereby give permission to Somnologix, Ltd d/b/a 4 BETTER SLEEP and P. Terrence Moore, MD to send me personal health information via unencrypted text message.

Signature_____

Printed name _____

Date_____

Print phone number authorized to receive texts: _____

OPTION 2—DO NOT ALLOW UNENCRYPTED TEXT MESSAGING
I do not wish to receive personal health information via text message

Signature_____

Printed name _____

Date_____

I understand that with regard to HIPAA compliance, the most secure way to obtain instruction is in person. *Signature:*_____

I understand that I may revoke any permission given above at any time to receive electronic communication, and I will notify you in writing if I choose to revoke said permissions.
*Signature:*_____

P. Terrence Moore, MD

To our patients:

Thank you for choosing Dr. Moore and 4 Better Sleep for your medical care. We appreciate that you have entrusted us with your health care needs, and we are committed to providing your the best care possible.

We look forward to meeting with you! To make the most of our time together in clinic, please complete all new patient paper work prior to the arrival of your appointment. This can be done through our online portal. All paper work **MUST** be completed by the day of your appointment confirmation. Failure to do this will result in the cancellation of your appointment.

Scheduling Policy

Appointment Confirmations:
Our office will call to confirm appointments within **72** hours or your scheduled appointment. Please make sure to return the call to confirm within **24** hours of the call. Appointments not confirmed may be subject to cancellation.

Late Appointment Arrivals:
As a courtesy to others, we reserve the right to reschedule your appointment if you are more than **10 minutes late**.

Missed Appointment Fees:
We require a 48 hour cancellation notice. If you miss your appointment, or do not cancel within the require notice, additional fees may apply:

- Follow-Up visit: $50.00
- New Patient visit: $150.00
- Office Procedures: $75.00
- Sleep Studies: $250.00

It is very important that you inform a member of our staff ANY insurance or demographic changes.

Paul Terrence Moore, MD
Practice Financial Policy Statement

Thank you for choosing our practice for your health care needs. The following is a statement of our Financial Policy, which you must read, agreed to and sign, prior-to treatment. The policy applies to all service rendered by our office.

Patient Payment Policy Guidelines:
Patients and/or their guardians are financially responsible for all charges, regardless of third-party involvement. Full payment is due at time of service, unless prior insurance billing arrangements have been made. Patients with insurance will be required to pay all 'out-of-pocket' financial obligations at time of service. We accept: Cash, Check, Bank Debit Card, the following credit cards: Visa, AMEX MasterCard, and Discover.

Patient Responsibilities and Financial Policies:
Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you MUST inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written Referrals, Pre-authorizations or Pre-certifications from your primary care physician or health plan prior-to rendering services. If we have not received the necessary authorizations prior-to your appointment, you will be required to sign a waiver acknowledging your financial responsibility for the encounter charges or the appointment will be rescheduled. Any coverage or payment dispute is a matter between the policyholder and the insurance company. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patient with Private Insurance / Medicare: Our physicians participate with the Medicare Program and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the 'assignment of benefits' below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., Indemnity or 'Out-of-Network' plans), the practice will expect full payment from the patient at time of service or will balance bill the patient the full remaining balance after payment is received from insurance.

Patient Payment Agreement:
I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 15 days of notice.

I understand that if I fail to pay outstanding balances or make payment arrangements within 60 days, the amount due will be considered delinquent and subject to legal action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to 'collections', I agree to pay all collection costs, including, but not limited to, court costs, attorneys fees , and accrued interest charges to date.

I understand that if my check is dishonored or returned for any reason, there will be a $25.00 processing fee as well as the amount still owed on my account.

I agree to pay a $150.00 fee for a new patient visit, $50.00 for follow up visit, $75.00 for office procedures and $250.00 for sleep studies not canceled at least 48-hours in advance. Copies of my medical records can be obtained with advanced notice for a fee of $50.00. The completion of special forms or reports has a minimum charge of $35.00 for each form.

In consideration for medical service rendered, I acknowledge receiving notice of the financial policy and agree to pay for said medical services according to the above terms. My signature below indicates that I have read and agree to the above policy.

Signature of Patient or Responsible Party	Print Full Name / Relationship to Patient	Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on 12/01/2014 and will remain in effect until it is amended or replaced by us.
We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.
You may request a copy of our Privacy Notice at any time by contacting our office. Information on contacting us can be found at the end of this notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we are not capable of an electronic format, a readable hard copy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $.50 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. Please contact our Office for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on December 01, 2014.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fund-raising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fund-raising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fund-raising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be $35.00 including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hard copy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Office for an explanation of our fee structure.

Amendment: You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US:
Practice Name: Dr. Paul Terrence Moore
Phone: 214-466-7222 Fax: 214-466-7220
Address: 8722 Greenville Avenue, Suite 102, Dallas, TX 75243

P. Terrence Moore, MD & 4 Better Sleep

May we leave personal/medical information on your phone and/or email?
Please check one.

Home:	☐ Yes	☐ No
Cell:	☐ Yes	☐ No
Email:	☐ Yes	☐ No

Discloser of Person Health Information (PHI) Check one below

☐ I authorize the disclosure of my protected health information to the person listed as my primary emergency contact. Name:_____

☐ I do NOT authorize the disclosure of my protected health information to the person listed as my primary emergency contact.

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, authorize the disclosure of my medical and/or other personal information necessary to process my claims and payment of medical benefits to my treating physician or supplier for services rendered by Dr. Moore and/or 4 Better Sleep.

Acknowledgment of Receipt of Financial Policies

I, _____, have been given a copy of the financial policies and understand my financial responsibilities for services rendered by Dr. Moore and/or 4 Better Sleep.

_____ _____

Patient Signature Date

If patient is a minor:

_____ _____

Legal Guardian Signature Date

_____

Relationship to patient