Sleep Matters MD
7530 Woodward Ave., Ste. A, Woodridge, IL 60517
630-297-8282 (Office) 630-278-6118 (Fax)
www.sleepmattersmd.com

Patient Demographic Information:

TODAY'S DATE: ____/____/____ AGE: _____ MARITAL STATUS: _____

PATIENT NAME: _____NICKNAME: _____

DATE OF BIRTH:____/____/____ SOCIAL SECURITY #: _____GENDER:_____

PREFERRED LANGUAGE: _____ RACE:_____ETHNICITY: _____

EMAIL ADDRESS: _____

HOME ADDRESS:

_____

Street City State Zip

HOME PHONE: _____CELL PHONE: _____

WORK PHONE: _____EMAIL: _____

EMPLOYER: _____OCCUPATION: _____

WORK ADDRESS:

_____

Street City State Zip

EMERGENCY CONTACT: _____PHONE: _____

RELATION: _____

PHARMACY: _____PHONE: _____

Name & Address or Location

PRIMARY CARE PHYSICIAN: _____PHONE: _____

REFERRING PHYSICIAN: _____PHONE: _____

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INSURANCE INFORMATION:

PRIMARY MEDICAL INSURANCE:

_____

Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: ____/____/____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY MEDICAL INSURANCE: (if applicable)

_____

Name & Address

POLICY HOLDER: _____ POLICY HOLDER DATE OF BIRTH: ____/____/____

POLICY NUMBER: _____ GROUP NUMBER: _____

HOW DID YOU HEAR ABOUT US?

☐ PHYSICIAN (Name: _____) ☐ FORMER PATIENT

☐ FAMILY/FRIEND (Name: _____) ☐ SOCIAL MEDIA

CPAP/SLEEP STUDY INFORMATION (IF APPLICABLE):

Date and place of first and last sleep study: _____

What kind of CPAP machine do you have: _____

What is the DME Company where you get your supplies: _____

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Sleep Questionnaire:

Demographics:

Patient Name: _____ DOB: _____ Date: _____

Sleep Complaint:

1. Briefly describe your sleep complaint: _____

Sleep Schedule:

2. What is your normal bedtime? _____
3. How long does it take for you to fall asleep? _____
4. How many times do you wake up at night? _____
5. What is your wake time? _____
6. Do you take any naps? ☐ Yes ☐ No ☐ Sometimes

Social History:

1. Do you currently smoke cigarettes? ☐ Yes ☐ No ☐ Former ☐ Cigars ☐ Vaping ☐ Chewing tobacco
2. Do you drink alcohol? ☐ Yes ☐ No ☐ Socially ☐ Former
3. Do you drink anything with caffeine? ☐ Yes ☐ No ☐ Former
4. Do you exercise? ☐ Yes ☐ No ☐ Sometimes

Medical/Surgical History:

_____

Height/Weight:

_____

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Insomnia Severity Index: *Please circle the appropriate response for each item.*

Please rate the CURRENT severity of each sleep problem listed below.	**None/Not Applicable**	**Mild**	**Moderate**	**Severe**	**Very Severe**
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Waking up earlier than intended	0	1	2	3	4
	Very Satisfied	**Satisfied**	**Moderately Satisfied**	**Dissatisfied**	**Very Dissatisfied**
4. How satisfied/dissatisfied are you with your CURRENT sleep pattern?	0	1	2	3	4
	Not at all	**A Little**	**Somewhat**	**Much**	**Very Much**
5. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work all day/daily chores, concentration, memory, mood, etc.) CURRENTLY?	0	1	2	3	4
6. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?	0	1	2	3	4
7. How WORRIED/DISTRESSED are you about your current sleep problem?	0	1	2	3	4

Epworth Sleepiness Scale: *How likely you are to fall asleep or doze in each situation.*

Chance of Falling Asleep or Dozing ***Place a check mark in the appropriate box to the right for each item.***	**No Chance (0)**	**Slight Chance (1)**	**Moderate Chance (2)**	**High Chance (3)**
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 lunch without alcohol				
8. In a car, while stopped for a few minutes in traffic				

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HOME SLEEP STUDY EQUIPMENT AGREEMENT:

TO ALL OUR PATIENTS,

THIS IS AN ACKNOWLEDGEMENT WHICH STATES THAT SLEEP MATTERS MD IS PROVIDING YOU, _____(PATIENT NAME), THE EQUIPMENT TO COMPLETE YOUR HOME SLEEP STUDY. YOU ARE REQUIRED TO COMPLETE THIS HOME SLEEP STUDY WITHIN THE NEXT SEVEN (7) DAYS. IF YOU FAIL TO COMPLY, YOUR CREDIT CARD WILL BE CHARGED $100.00 FOR THE EQUIPMENT. IF YOU WOULD LIKE THE SLEEP STUDY EQUIPMENT TO BE SHIPPED TO YOU, A SHIPPING COST OF $15.00 WILL BE CHARGED. IF THE REUSABLE EQUIPMENT IS LOST, STOLEN OR DAMAGED, A CHARGE OF $2500 WILL BE CHARGED.

EXCEPTION: IF YOU CHOOSE NOT TO COMPLETE THE HOME SLEEP STUDY, YOU MUST RETURN THE **UNOPENED** EQUIPMENT WITHIN FIVE (5) DAYS OF RECEIPT OF THE EQUIPMENT.

☐ AGREED

CARD NUMBER_____EXP: _____CVV:_____

PATIENT SIGNATURE: DATE:

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Sleep Matters MD as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.
- Patients may incur and are responsible for the payment of additional charges at the discretion of Sleep Matters MD. These charges may include (but are not limited to):
    - Charge for returned checks ($25.00).
    - Charge for missed appointments without 24 hours advance notice ($50.00)
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions (as per time)
    - Charge for the copying and distribution of patient medical records ($35.00)
    - Charge for extensive forms completion (as per time)
    - Any costs associated with collection of patient balances.

Patient Authorizations

- By my signature below, I hereby authorize Sleep Matters MD and the physicians, staff, and hospitals associated with Sleep Matters MD to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.
- By my signature below, I hereby authorize assignment of financial benefits directly to Sleep Matters MD and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.
- By my signature below, I authorize Sleep Matters MD personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.
- By my signature below, I authorize Sleep Matters MD to securely store my credit card information and only charge it should I have an outstanding balance or any leftover balance from a processed claim in the future. I am aware that the storage system used is fully compliant to the highest level of credit card storage security regulations. Once stored, I am aware that only the last 5 digits of my card are viewable by Sleep Matters MD personnel. I understand that I am responsible for all charges for services that I receive from Sleep Matters MD, and that if the patient responsibility portion of my charges (including charges applied to my deductible and/or coinsurance) is not paid in full within thirty (30) days following the receipt of the patient financial responsibility statement mailed from the Sleep Matters MD Billing Office, Sleep Matters MD will bill my stored credit card for the outstanding balance due.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian Date

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Patient or Guardian Date

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BENEFITS ASSIGNMENT

Last Name First Name DOB

Address SSN

AUTHORIZATION FOR MEDICAL INFORMATION RELEASE - I authorize Sleep Matters MD to release to my insurance company, any medical information needed to determine benefits payable for related services.

AGREEMENT OF RESPONSIBILITY – I understand that professional services are rendered and charged to the patient. CO-PAY IS DUE AT THE TIME OF SERVICE (Co-insurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance, as well as attorney fees and costs to Sleep Matters MD if this matter is referred to collection.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS – I authorize use of this form for release of information needed to process claims to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping obtain payment from my insurance companies. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive monthly statements for any balance due by me. I also understand, full payment is required to be made on receipt of your 1st statement after insurance has met their obligation.

MEDICARE AUTHORIZATION – I request payment of authorized Medicare benefits be made on my behalf to Sleep Matters MD, for any services provided to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents, any information needed to determine these benefits or benefits payable for related services.

I understand my signature requests payment to be made and authorize release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes release of information to insurer or agency shown. In Medicare assigned cases, the physician/supplier agrees to accept the charge of determination of the Medicare carrier as the full charge – the patient is responsible for deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP/SUPPLEMENTAL AUTHORIZATION - I request payment of authorized Medigap/Supplemental benefits on my behalf to Sleep Matters MD, for any services furnished me by that physician/supplier. I authorize holder of my medical information to release to Medigap/Supplemental and its agents, any information needed to determine these benefits or the benefits payable to related services.

AUTHORIZATION – INSURANCE/FINANCIAL MATTERS - By my signature, I also authorize Sleep Matters MD, to discuss financial/insurance matters on my behalf with those persons designated below (Please PRINT complete names & relationship):

PATIENT: DATE:

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Medical Release of Information

Patient Name: _____ DOB: _____

I hereby give my consent and authorize to the following facility:

Sleep Matters MD
7530 Woodward Ave, Ste, A
Woodridge, IL 60517
Tel: 630-297-8282 Fax: 630-278-6118

To have access to my;

Medical Records, Physician Notes, Laboratory Reports, Pathology Reports, Radiology Reports, Procedural/Operative Reports and Consultation Reports.

I understand that I may revoke this consent in writing at time, although not retroactively, and that upon fulfillment of the above request medical information or the lapse of one (1) year from the date of signature, whichever comes first, this consent will automatically expire without my expressed revocation. A photocopy of this authorization shall be as valid as the original.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 C F R 165.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. The patient's medical record is privileged information, which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patients.

I understand that the information in my health record may include information relating to sexually transmitted diseases, such as the Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

Patient must sign unless he/she is a minor under 18 or is unable to sign. If signature is not of a patient, indicate the relationship to patient.

Patient Signature: _____ Date: _____

Relationship to Patient: _____

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NOTICE OF PRIVACY PRACTICES

Please sign last page after reading.

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.

If you have any questions about this notice please contact our office at 630-297-8282.

Sleep Matters MD is committed to treating and using your Protected Health Information (PHI) responsibly. As of April 2003, the Health Insurance Portability & Accountability Act (HIPAA) requires us to:

1. Maintain the privacy of medical information provided to us.
2. Prevent inappropriate use of that information.
3. Provide a notice of our legal duties and practices
4. Abide by the terms of our notice of privacy practices currently in effect.
5. Protect and enhance patient rights by giving you, the patient, control of your medical information.

This notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices, or one may be accessed on our website www.sleepmattersmd.com or calling the office and requesting for a revised copy be sent to you via mail, or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Protected health information is an individual's healthcare information that is transmitted or maintained by a covered entity in any form (paper, electronic, or verbal).

You will be providing us with personal information such as, but not limited to:

1. Your name, address and phone number
2. Information relating to your medical history
3. Your insurance information and coverage
4. The name of your referring and/or primary care physician

Uses for protected health information (PHI):

1. Basis for planning your care and treatment.
2. Legal document describing the care you received.
3. Means of communication among the many health professionals who contribute to your care.
4. Means by which you or your insurance company (payer) can verify that services billed were actually provided.
5. A source of data for our planning and marketing.
6. A source of information for public health officials charged with improving the health of this state and the nation.
7. A tool with which we can work to improve the care we render and the outcomes we achieve.

Uses and disclosures of Protected Health Information Based Upon Your Written Consent.

You will be asked by your physician to sign a consent form. Once you have consented to use and disclose your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section. 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. Your protected health information may also be used and disclosed to facilitate payment of your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

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 coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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 admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you physician's 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 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 will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer: We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object. We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.
Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been of victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have any questions about access to your medical record.

You have the right to request a restriction of you 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 you care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If 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. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you with to request with your physician. You may request a restriction by contacting our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable request. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request and explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. 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 electronically.

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.
You may contact our office at 630-297-8282 for further information about the complaint process.

Disclosures
This notice was published and becomes effective on May 08, 2023.

Attestation
I, , hereby give my consent to Sleep Matters Ltd DBA Sleep Matters MD, to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.
I acknowledge having received a copy of the Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that the practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Sleep Matters MD. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my Protected Health Information.
I understand that, under the HEALTH Insurance Portability & Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health Information.
I understand this Information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in WRITING that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Date

Patient Representative/Parent Date

FOR OFFICE USE ONLY:
I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so: Reason:

Practice Representative Date