Patient Information

ENT Medical Services Sleep Center
2901 Northgate Drive, Suite A
Iowa City, IA 52245
P (319) (319) 338.2101 F (319) 338.1973

Note: **Do NOT email this form.** Bring it with you to your first visit.

Patient Name: _____ SSN: _____
Patient Address: _____
Patient DOB: _____ Age: _____ Marital Status: _____
Race: _____ Ethnicicity: _____ Language: _____
Sex: _____ Patient Phone: _____ Cell: _____
Patient Employer: _____ Work: _____

Reason for visit: _____
Drug Allergies: _____
(Write none if none)

Family Doctor: _____ Referring Doctor: _____

If the patient is a minor, dependent or college student, who is responsible for the account?
❑ Mother ❑ Father ❑ Both ❑ Other_____

GUARANTOR INFORMATION

Name: _____
Address: _____
_____
Phone: _____
Spouse: _____

ALTERNATE GUARDIAN INFORMATION

Name: _____
Relationship_____
Address: _____
Phone: _____
DOB_____

EMERGENCY CONTACT INFORMATION

Who do we contact in an emergency? _____
Relationship: _____ Contact Phone Number: _____
Contact Work Phone: _____ Cell: _____
Pharmacy & Location: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Subscriber Employer: _____ Relationship to Patient: _____

Patient Information

Insurance Cont.

Secondary Insurance:
Primary Insurance: _____ ID: _____ Group #: _____
Subscriber Name: _____ Subscriber DOB: _____
Subscriber Employer: _____ Relationship to Patient: _____

INSURANCE RELEASE AND HIPAA PRIVACY ACKNOWLEDGEMENT INFORMATION

I HEREBY AUTHORIZE **ENT MEDICAL SERVICES, PC,** TO RELEASE TO MY INSURANCE COMPANY ANY NECESSARY INFORMATION NEEDED TO FILE AND EXPEDITE PAYMENT ON MY CLAIM. I FURTHER ASSIGN ANY BENEFITS PAYABLE ON MY BEHALF TO **ENT MEDICAL SERVICES, PC.** I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I HAVE BEEN PRESENTED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES DETAILING HOW MY HEALTH INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW AND OUTLINING MY RIGHTS REGARDING MY HEALTH INFORMATION.

Patient Signature: _____ Date: _____

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Patient Name: _____ SSN: _____

Patient Address: _____

Patient DOB: _____ Age: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Language: _____

Sex: _____ Patient Phone: _____ Cell: _____

Physician who referred you to our sleep center: _____

SLEEP HISTORY / HABITS / HYGIENE

1. What is the main problem with your sleep? _____

_____

2 How long have had this sleep problem? _____

3. Does anything specific seem to make your sleep problem better or worse (describe)? _____

_____

4. Do you have other problems with your sleep? ❑ Yes ❑ No

If YES, please describe the problem(s), and tell us how long you have had the problem(s):

_____

_____

5. Have you ever been evaluated in a sleep disorders center before? ❑ Yes ❑ No

If YES, please tell us when and where you were evaluated. Include any treatment recommendations, and whether or not the treatment worked. _____

_____

6. What time do you normally go to bed on week days or days that you work? _____

7. What time do you normally get up on weekdays or days that you work?

_____

8. Do you keep a regular sleep/wake schedule? ❑ Yes ❑ No

9. How long does it usually take you to fall asleep? _____

10. How many hours do you think you sleep on a average night? _____

11. How often do you wake up during the night? _____

12. How long does it take you to fall back asleep after you wake up? _____

Self Assessment and History

13. In the first few minutes after you wake up in the morning, do you feel:

❑ Very tired ❑ Slightly drowsy ❑ Very tired ❑ Very tired ❑ Wide awake / alert

14. Do you nap during the day? ❑ Yes ❑ No

If YES, how many naps per day, and how long on average? _____

15. Do you use supplemental oxygen at night? ❑ Yes ❑ No

If yes, what flow are you on? _____

16. Do you use the oxygen during the day as well? ❑ Yes ❑ No

17. What type of bed do you sleep in? (Please check the appropriate answer)

❑ Regular mattress ❑ Water bed ❑ Air mattress ❑ Adjustable bed ❑ Sofa bed ❑ Floor

❑ Other: _____

18. Do you have a regular sleeping partner? ❑ Yes ❑ No

If yes:

Does your partner's sleeping habits bother you? ❑ Yes ❑ No

Do your sleeping habits bother your partner? ❑ Yes ❑ No

INSOMNIA

(N) = Never (R) = Rarely (S) = Sometimes (F) = Frequently (A) = Always

For the following questions please **circle** the best answer.

19. I have trouble falling asleep.	N	R	S	F	A
20. I have thoughts racing through my head.	N	R	S	F	A
21. I feel sad or depressed.	N	R	S	F	A
22. I worry about things.	N	R	S	F	A
23. I become anxious or nervous when I try to fall asleep.	N	R	S	F	A
24. I wake up and have trouble falling back asleep.	N	R	S	F	A
25. I wake up and have trouble falling back asleep.	N	R	S	F	A
26. I wake up too early and can't get back to sleep.	N	R	S	F	A
27. I sleep better when I am not in my own bed.	N	R	S	F	A
28. I use alcohol to help me fall asleep.	N	R	S	F	A
29. I use sleeping pills to help me fall asleep.	N	R	S	F	A

Self Assessment and History

PARASOMNIAS

(N) = Never (R) = Rarely (S) = Sometimes (F) = Frequently (A) = Always

For the following questions please **circle** the best answer.

30. I have nightmares. N R S F A
31. I walk in my sleep. N R S F A
32. I wet the bed. N R S F A
33. I wake up with a choking, gagging sensation in my throat. N R S F A
34. I physically act out my dreams, punching, kicking, yelling, etc. N R S F A

SLEEP / WAKE CYCLE DISORDERS

35. I grind my teeth at night. N R S F A
36. Do you currently work rotating shifts, or the night shift? ❑ Yes ❑ No
37. Do you have trouble sleeping when you are working rotating shifts? ❑ Yes ❑ No

MOVEMENT DISORDER

38. Do you maintain the same sleep/wake cycle on your days/nights off? ❑ Yes ❑ No
39. Do you roll around and thrash while sleeping? ❑ Yes ❑ No
40. Are the bedcovers extremely messy when you awaken? ❑ Yes ❑ No
41. Do you awaken yourself with kicking or jerking of your legs? ❑ Yes ❑ No
42. Does your sleeping partner complain about you kicking or jerking while you sleep?
    ❑ Yes ❑ No
43. Do you have restless legs while you sleep (a need to keep moving your legs or a crawling or
44. burning sensation in your legs that keeps you from falling asleep)? ❑ Yes ❑ No

EXCESSIVE DAYTIME SLEEPINESS / NARCOLEPSY

45. Are you bothered by restless legs while awake? ❑ Yes ❑ No
46. Have you ever caused an accident or a near-miss accident because of falling asleep?
    ❑ Yes ❑ No
47. Do you ever have very vivid dreams just as you are falling asleep or waking up?
    ❑ Yes ❑ No

Self Assessment and History

48. Which of the following best describes you:

❑ I typically feel wide awake and full of energy all day

❑ I typically feel mildly tired/sleepy during the day.

❑ I typically feel very tired/sleepy during the day.

❑ I typically feel exhausted during the day and will fall asleep frequently.

49. Do you snore? ❑ Yes ❑ No

If YES, how frequently do you snore:

❑ I snore once a week or so.

❑ I snore two or three times a week.

❑ I snore part of the night.

❑ I snore all night long.

50. If you snore, does anything make your snoring better (i.e., sleeping on your side, using a special pillow, etc)?

_____

51. If you snore, does anything make your snoring worse (i.e., sleeping on your back, drinking alcohol before bedtime, heavy meal, etc)? _____

52. If you snore, how loud do you think your snoring is:

❑ mild ❑ moderate ❑ loud ❑ very loud

53. Have you been told that you stop breathing or hold your breath while asleep? ❑ Yes ❑ No

If YES, how frequently do you stop breathing:

❑very seldom ❑ occasionally ❑ frequently ❑ all the time

54. Does the frequency of how often you stop breathing vary with your sleep position?

❑ Yes ❑ No

55. Have you been told that you gasp for breath while sleeping? ❑ Yes ❑ No

56. Have you been told that you moan and groan while sleeping? ❑ Yes ❑ No

Do you have any of the following?

Heart Disease	❑ Yes ❑ No
Respiratory Disease (lung/breathing problems)	❑ Yes ❑ No
Hypertension (high blood pressure)	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No

Self Assessment and History

Hypoglycemia (low blood sugar)	❑ Yes ❑ No
Anemia or other blood disorders	❑ Yes ❑ No
Strokes or CVA's	❑ Yes ❑ No
Seizures or Epilepsy	❑ Yes ❑ No
Gastro-intestinal Problems (stomach or bowel problems)	❑ Yes ❑ No
Mental Illness (depression, anxiety, psychosis, etc.)	❑ Yes ❑ No
Kidney / Bladder Disease	❑ Yes ❑ No
Sinus / Tonsil / Adnoid Problems	❑ Yes ❑ No
Thyroid Problems	❑ Yes ❑ No
Migraine Headaches	❑ Yes ❑ No
Cluster or Morning Headaches	❑ Yes ❑ No
Neurological Problems (concussions, fainting spells, etc.)	❑ Yes ❑ No
Chronic or Recurring Back Pain	❑ Yes ❑ No
Injury to the Face, Neck, Head, Throat or Chest	❑ Yes ❑ No
Cancer	❑ Yes ❑ No

57. If you answered YES to any of the above, please use this space to describe the problem(s):

_____

_____

58. What medications are you now taking, including over-the-counter medicine:

Drug Name (Generic)	Dosage	Frequency	**Drug Name (Generic)**	Dosage	Frequency

Self Assessment and History

59. Do you have any drug allergies (write 'None' if the answer is no): _____

_____

_____

60. Do any of the medications you are now taking affect how you sleep? ❑ Yes ❑ No

If YES, please explain: _____

_____

61. How much of the following do you drink each day? Coffee: _____ Soft drinks: _____

Decaffeinated Coffee: _____ Decaffeinated Soft Drinks: _____ Tea: _____

62. How much of the following do you drink per week?

Beer _____ Wine _____ Liquor _____

63. Do you use alcohol to help you fall asleep? ❑ Yes ❑ No

64. What time of day is most of your alcohol consumed? _____

Have you used any of the following in the past 6 weeks: (note: the information in this questionnaire is confidential and not released outside the ENT Sleep Center).

Marijuana

Hallucinogenics (LSD, PCP)

Cocaine / Crack

Stimulants

Depressants

Narcotics (Heroin, Opium, Morphine)

Do you smoke?

Did you smoke in the past?

How long ago did you stop smoking?

How much do you smoke?

Do you smoke: _____ cigarettes _____ cigars _____ pipe

Do you use chewing tobacco? ❑ Yes ❑ No

In your own words, tell us what type of hep you are looking for: _____

_____

Additional Comments: _____

_____

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Patient Name: _____ Date: _____
Date of Birth: _____ ENT Dr.: _____
Gender: _____ Age: _____ Referring Provider: _____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Occupation: _____
Are you here with anyone today? ❑ No ❑ Yes — relationship: _____

MEDICATIONS: List ALL the medications you are currently taking (including over-the-counter medications).

Drug Name (Generic)	Dosage	Frequency	**Drug Name (Generic)**	Dosage	Frequency

ALLERGIES TO ALL MEDICATIONS: List all your medication allergies.

Medication	Allergic Reaction

Patient History

PAST MEDICAL HISTORY - List ALL your Prior Surgeries, Medical Conditions & Major Injuries

Medical Condition/Surgery/Illness/Injury	Year	Physician	Town/Hospital

SOCIAL HISTORY

Have you ever smoked? ❑ Yes ❑ No

If yes, do you still smoke? ❑ Yes ❑ No ❑ Occasionally

If you quit completely, when did you quit completely? _____

How many packs per day during the time that you smoked? _____

For patients 12 years and younger (check at least one): Tobacco exposure? ❑ At home

❑ Perinatal ❑ Neither

Do you drink alcohol?

❑ 6 or more drinks per day ❑ 3-6 drinks per day ❑ 1-2 drinks per day ❑ Occasionally

❑ Never

Do you use street or recreational drugs?

❑ Daily ❑ Occasionally ❑ Never If yes, what recreational drugs do you use? _____

_____

FAMILY HISTORY

What runs in your family?	*Who had it?*

Patient History

REVIEW OF SYMPTOMS — Check only the ones you have NOW or had RECENTLY

CONSTITUTIONAL	❑ Fever ❑ Weight loss ❑ Weight gain
ALLERGIC	❑ Sneezing ❑ Hay fever ❑ Nasal allergies
EYES	❑ Double vision ❑ Excessive Tearing ❑ Itchy/watery eyes
EARS	❑Ear pain ❑ Ear drainage ❑ Ear infections ❑ Hearing loss ❑ Ringing/tinnitus/unwanted noise ❑ Wax problems ❑ Itchy ears
NOSE	❑ Post-nasal drip/drainage ❑ Congestion ❑ Obstruction ❑ Bloody noses ❑ Decreased smell ❑ Sneezing ❑ Runny nose ❑ Sinusitis episodes ❑ Facial pressure
MOUTH	❑Bad breath ❑ Mouth sores/spots ❑ Dry mouth ❑ Bad teeth ❑ Loss of taste
THROAT/NECK	❑ Sore throat ❑ Bad tonsils ❑ Tonsil debris ❑ Hoarseness ❑Pain on swallowing ❑ Difficulty swallowing ❑ Choking ❑ Throat clearing ❑ Neck pain ❑ Neck mass or lump
CARDIOVASCULAR	❑ Hypertension (high blood pressure) ❑ Palpitations/Rapid heart beat
RESPIRATORY	❑ Wheezing ❑ Cough
GASTROINTESTINAL	❑ Heartburn ❑ Vomiting ❑ Diarrhea
GENITOURINARY	❑ Bedwetting
HEMATOLOGIC	❑ Easy bruising/bleeding ❑ Taking blood thinners/anticoagulants ❑ Aspirin use
ENDOCRINE	❑ Hypothyroidism ❑ Hyperthyroidism ❑ Diabetes
MUSCULOSKELETAL	❑ Arthritis ❑ Fibromyalgia
SKIN	❑ Rash ❑ Ulcerative lesions ❑ Enlarging lesions ❑ Persistent lesions
NEUROLOGICAL	❑ Headaches ❑ Migraines ❑ Facial pain ❑ Dizziness ❑ Memory loss
PSYCHIATRIC	❑ Bipolar disorder ❑ Drug use ❑ Alcohol abuse ❑ Depression ❑ Anxiety
SLEEP	❑ Snoring ❑ Fatigue ❑ Sleep disturbance

Financial Policy

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This agreement is between ENT Medical Services, P.C. as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

IT IS YOUR RESPONSIBILITY TO KNOW THE REQUIREMENTS OF YOUR INSURANCE COMPANY. THIS INCLUDES PARTICIPATION, IN NETWORK, OUT OF NETWORK, REFERRAL REQUIREMENTS, SECOND OPINION, PRIOR APPROVAL, PRE-CERTIFICATION AND OUTPATIENT AND / OR INPATIENT STATUS. YOU ARE ALSO RESPONSIBLE FOR ALL CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLE REQUIRED BY YOUR INSURANCE PLAN. YOU MUST BE AWARE OF ANY PRE-EXISTING CONDITIONS, WAIVERS OR WAITING PERIODS, OUTLINED BY YOUR INSURANCE CARRIER.

MONTHLY STATEMENTS: If you have a balance on your account, you will receive a monthly statement. It will show your current balance, insurance adjustments/payments and monthly interest on balances over 60 days. Unless other arrangements are approved by ENT Medical Services, P.C., in writing, the balance on your account is due, in full, and payable within 60 days from the date of service.

INSURANCE CLAIMS: We will gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services.

SURGICAL PROCEDURES: Twenty-five percent (25%) of your insurance deductible is due prior to all surgical procedures.

CO-PAY: Co-payments are due at the time of service. Your contract with your insurance company requires that you pay all applicable co-payments and deductibles. Failure to comply could lead to loss of insurance coverage.

DIVORCE: In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect fro the other parent.

WORKERS COMPENSATION: We require written approval or authorization by your employer and/or Worker's Compensation carrier PRIOR to your initial visit. If your claim is denied, you are responsible for payment in full.

MONTHLY PAYMENT OPTIONS

Automatic withdrawal from your checking/savings account ON BALANCES OVER $300 without interest. We will include a service fee for all rejected withdrawals due to insufficient funds.

Financial Policy

Cash, check, credit card or money order with interest of 1.5% monthly or 18% annually. This excludes all USA government-sponsored payers: i.e., Medicare, Title 19 and Tricare.

In addition, you may use CareCredit®. Please contact our insurance department regarding this product. Literature is available upon request in our reception area.

UNINSURED PAYMENT OPTIONS: Payment is required in full from the date of service unless other arrangements have been made, in writing, with ENT Medical Services, P.C. A 20% discount will be taken if the balance is paid in full on the date of service.

EXTENSIVE PAYMENT AND/OR LARGE BALANCES: We understand that medical bills can add up quickly and you may not be able to pay the balance in full within 60 days. We would suggest securing a bank loan for balances over $1000.00 if necessary, as we are unable to extend credit for long periods of time.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt by means of a collection agency or an attorney.

MONTHLY PAYMENT SCHEDULE FOR PAYMENT BALANCE

$ 0 - $50	Payment in Full
$ 50 - $150	2 Monthly Payments
$150-$300	3 Monthly Payments
$300-$500	4 Monthly Payments
$500-$1000	6 Monthly Payments
$2000-$3000	12 Monthly Payments
$3000-$5000	18 Monthly Payments
$5000-above	24 Monthly Payments

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

Effective Date: Once you sign this agreement, you agree to all of the terms and conditions herein and this agreement will be in full force and effect.

Patient Name: _____ Date: _____

Patient Signature: _____

Responsible Party (If not the patient): _____

Co-Signature (if required): _____

ENT MEDICAL SERVICES
SLEEP CENTER, PLC
2901 Northgate Drive
Iowa City, IA 52245
319.338.2101 / 319.338.1973 Fax

Before Your Sleep Study:

1) Hair clean and dry
2) Try not to nap (come in sleepy)
3) Eat as you normally would
4) Bring comfortable clothing to sleep in
5) You are welcome to bring your own pillow
6) Please bring your completed questionnaire
7) If you take any medications that make you drowsy or keep you awake, please call the sleep center prior to your test. If your physician has prescribed you a sleeping pill, please take the prescribed sleeping pill with you to the sleep center. If you have trouble falling asleep the sleep tech will instruct you to take this medication. Feel free to contact the sleep center with any questions or if you need to change your study time to fit your schedule.

8) Your technician will be awakening you between 5:30 and 6:00 a.m. You may need accompaniment after the test if you have problems staying awake while driving. Please let the sleep technician know if you need to arrive later or leave earlier. If you need to cancel your appointment, please call the sleep center as soon as possible. (The phone number is listed above; you can leave a message if there is no answer.)

ENT MEDICAL SERVICES
SLEEP CENTER, PLC
2901 Northgate Drive
Iowa City, IA 52245
319.338.2101 / 319.338.1973 Fax

Things to know before your sleep study:

Our policy at ENT MEDICAL SERVICES SLEEP CENTER, PLC is to begin patient sleep studies at 9:00 p.m. and 10:00 p.m. We wake patients the following morning at 5:30-6:00 a.m.

If you are having a sleep study you must prepare for these times. If you take medications that may leave you drowsy in the morning, or if you do not normally get up at 5:30-6:00 a.m. and believe you will not be fully alert at that time, you must make accommodations to have a driver take you home.

We care deeply about your safety and do not want anyone to be driving if they are anything less than fully alert behind the wheel.

What to bring to your sleep study:

1. Something comfortable to sleep in, i.e. pajamas, gym shorts or sweat pants and T-shirt. The patient setup and electrode placement will take place in a room adjacent to your bedroom. You may also wish to bring a bathrobe.
2. Any medications you will need at bedtime or during the study.
3. If your physician has prescribed a sleeping pill for you; bring it with you. **Do not take a sleeping pill until you are advised to do so by the technician.**
4. Any toiletries you will need to prepare for sleep; and upon awakening.
5. The Patient Questionnaire and any other paperwork from your sleep packet that you have not already returned.

Please limit the items that you bring to necessity items only. The ENT MEDICAL SERVICES SLEEP CENTER, PLC is not responsible for any items left or misplaced at our facility.

Please sign below in the space indicated. By signing you are stating that you fully understand the contents of the above stated information regarding driving home after a sleep test at the ENT MEDICAL SERVICES SLEEP CENTER, PLC.

(PATIENT OR GUARDIAN SIGNATURE) (DATE)

ENT Medical Services Sleep Center, PLC
2901 Northgate Drive, Suite A
Iowa City, IA 52245

Freedom of Choice Statement

ENT Medical Services Sleep Center, PLC is required to provide information about your freedom of choice regarding the selection of the facility you have chosen for your sleep study.

I understand that I may choose where I get my sleep study. This has been explained to me. I understand that my doctor has partial ownership in the ENT Medical Services Sleep Center, PLC. I have freely chosen ENT Medical Services Sleep Center, PLC to perform my sleep study. I understand that, if needed, I may get sleep studies done at another facility. If I need my sleep study(s) or report(s) to take to another facility or doctor I understand that I will be required to sign a release of information and I will receive copies of the sleep study(s) and/or report(s).

I authorize the release of any medical or other information needed to process my claim with my insurance carrier, and request payment of benefits be made directly to ENT Medical Services Sleep Center, PLC, on my behalf.

Patient Name (please print): _____

Patient /Legal Guardian Signature: _____

Relationship to Patient: _____ Date: _____

Charge For Missed Appointment

Occasionally, an event may come up that would necessitate canceling your appointment at our sleep lab. If such an event should arise, please provide a minimum of 24-hour notice.

If you fail to come to your appointment or provide less than 24 hours notice, you will be charged **$500**. Your insurance carrier won't pay for this broken promise. This amount will be charged to you. Payment in FULL is expected within 10 business days.

There may be times when inclement weather does not allow you the window to call within 24 hours. In these cases please call as soon as you know you will not be able to keep your appointment and you will not be charged the $500 fee. Failure to call will in fact incur the charge.

Please call us, if you are unable to keep your appointment. You can reach us Monday through Friday, 8:00 AM till 4:30 PM at (319) 338-2101. Or, you can leave a message between 6:00 PM and 8:30 PM by calling the same number.

Notice of Privacy Practices
ENT Sleep Center

Effective Date: *9/23/2013*

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:
Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245 – (319)351-5680

OUR Commitment to Your Privacy:

ENT Medical Services, P.C. is dedicated to maintaining the privacy of your individually protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you using your PHI.

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that are currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the otolaryngology (ear, nose and throat) care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a

close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. 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.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will

make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to: Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245 – (319)351-5680. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site: https://sleepcenterofiowa.com. To obtain a paper copy of this notice, please ask the front desk staff or you can request one in writing to: Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Privacy Officer, ENT Medical Services, 2615 Northgate Drive, Iowa City, IA 52245. All complaints must be made in writing. **You will not be penalized for filing a complaint**.