



PERSONAL INFORMATION		
Last Name:	First Name:	Middle Initial:
Social Security (SS) #:	Date of Birth (DOB):	Gender: M F
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail Address:		
Employer:		
Employed:	Full Time	Part Time Retired
Marital Status:	Single	Married Other
INSURANCE INFORMATION		
Primary Insurance		Secondary Insurance
Company:		Company:
Group #:		Group #:
Contract #:		Contract #:
Policy Holder:		Policy Holder:
Policy Holder SS#:	DOB:	Policy Holder SS#: DOB:
Policy Holder Employer:		Policy Holder Employer:
CONTACTS		
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:		Phone:

By signing this form,

- I authorize Sleep Centers of Texas to provide medical care to me as necessary.
- I authorize Sleep Centers of Texas to photograph me and include the photograph in my medical records; and to videotape me during the sleep study for diagnostic and/or treatment purposes.
- I authorize release of my medical records to my primary care physician, referring physician, consultants, and/or DME provider for the purpose of rendering treatment and/or ensuring continuity of care.
- I authorize release of my medical information to my insurance carrier to process my claims and payment from my insurance carrier directly to Sleep Centers of Texas for benefits, if any, otherwise payable to me.
- I understand that I am financially responsible for the deductible, co-payment, co-insurance and any other charges not covered by my insurance; and if I do not have insurance, I am obligated to pay the full amount.

Signature of Patient or Responsible Party _____
Date

Witness' Signature _____
Date



**AUTHORIZATION TO RELEASE
MEDICAL RECORDS**

Patient's Name: _____ Date of Birth: _____

Address: _____

**I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS TO
SLEEP CENTERS OF TEXAS**

Information to be Released: Medical History Physical Examination
Other: _____

From: _____

**I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS FROM
SLEEP CENTERS OF TEXAS**

Information to be Released: Medical History Physical Examination
Other: _____

To: _____

Patient's Signature

Date

Witness' Signature

Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Sleep Centers of Texas is required by law to protect the privacy of your protected health information ("medical information"). We are also required to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We are obligated to abide by terms of the Notice of Privacy Practices currently in effect. This Notice takes effect on April 14, 2003 and remains in effect until replaced.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are several ways in which your physician, our office staff and others outside of our office involved in your care are permitted to use and disclose your protected health information without your written authorization. Protected health information is individually identifiable health information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services rendered. The following list describes different ways that we are permitted to use and disclose your protected health information; however, this list is not meant to be exhaustive.

TREATMENT. We may use and disclose your medical information without your permission to provide, coordinate, or manage your health care. For example, we may request that your primary care physician share information with us and we may provide information about your condition to your primary care physician.

PAYMENT. We are permitted to use and disclose your medical information to obtain payment from your insurance plan for items and services rendered to you. For example, we may be required to disclose information about you to your health plan to obtain preauthorization for a sleep study and to seek payment for any services rendered.

HEALTH CARE OPERATIONS. We may use and disclose your medical information without your prior approval for health care operations. Health care operations include: healthcare quality assessment and improvement activities; reviewing and evaluating the competence, qualifications and performance of health care professionals; health care training programs; accreditation, certification, licensing and credentialing activities; medical records review, audits, and legal services; business planning, development, management and administrative activities.

We are also permitted to use and disclose your medical information without your prior approval, when authorized and required by law, for the following kinds of public health and benefit activities: 1) for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence; 2) to avert a serious and imminent threat to public health or safety; 3) for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud and abuse agencies; 4) for research; 5) to entities subject to FDA regulation regarding FDA-regulated products or activities; 6) in response to court and administrative orders and other lawful process; 7) to law enforcement officials with regard to crime victims and criminal activities; 8) to comply with OSHA or similar state laws regarding work-related illness or injury; 9) to comply with workers' compensation laws and similar programs; 10) to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; 11) to coroners, medical examiners, funeral directors, and organ procurement organizations; and 12) disclosures otherwise specifically required by law.

We may disclose your medical information to a family member, friend or any other person involved in your care or responsible for payment of your care but will disclose only the information that is relevant to his or her involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

In any other situation not described above, we will not use and disclose your medical information without your express written authorization. Uses and disclosures of your medical information for marketing and fundraising purposes and uses and disclosures that constitute sales of medical information about you will only be made with your signed permission. You have the right to opt out of receiving fundraising communications.

If you sign an authorization to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

PATIENT'S RIGHTS

With respect to your protected health information, you have certain rights:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with limited exceptions.
- You have the right to request that we contact you with confidential communications in a specific way. For example, you may request that we communicate with you through an alternate address or phone number or that we mail confidential communications to you in a closed envelope rather than postcard.
- You have the right to request that your protected health information be amended if you believe it is incorrect or incomplete. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.
- You have the right to request that we not use or share your protected health information with any party, including family or friends, regarding your treatment, payment of services, or our healthcare operations. If you pay in full for an item or service, you have the right to request that we not share your medical information with your insurer. Your request must state the specific restriction and to whom the restriction applies. Except in limited circumstances, we are not required to agree to the request if the request is not in your best interests.
- You have the right to request an accounting of all uses and disclosures of your protected health information, with the exception of those for your treatment, payment of services, and our healthcare operations, that we may have made during the six years prior to the date of your request.
- In the event of a breach that may have compromised the privacy or security of your protected health information, you have the right to receive notice of such breach.
- You have the right to obtain a paper copy of this Notice even if you receive this Notice by electronic mail or view it on our web site.

We reserve the right to change the terms of this Notice at any time and to make revisions applicable to all medical information that we maintain, including medical information we created or received before we made the change. For further information about our privacy practices, or to submit requests, please contact our Office Manager or Compliance Officer.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our Compliance Officer or with the U.S. Department of Health and Human Services, Office for Civil Rights, at 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to privacy in matters pertaining to your medical information. We will not retaliate against you if you elect to file a complaint under any circumstances.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature of Patient or Responsible Party

_____/_____/_____
Date



SLEEP QUESTIONNAIRE AND MEDICAL HISTORY

Name: _____ Social Security #: _____ Date: _____

Age: _____ Height: _____ Weight: _____ Male Female

Primary MD: _____ Referring MD: _____

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

SLEEP QUESTIONNAIRE

Chief Complaint(s)

Difficulty falling asleep Difficulty staying asleep Fatigue despite adequate sleep Snoring
Significant daytime drowsiness Witnessed apnea Gasping / choking upon awakening
Sleep walking / talking Night terrors Acting out dreams Legs kick / move while sleeping
Morning headaches Insomnia Other: _____

History of Present Illness

- 1. How long have you had this problem? < 1 month 1-6 months 6 months-2 years >2 years
2. Rate the severity of your problem. Mild Moderate Severe Problem only for others
3. Is your sleep-related problem getting worse? Yes No
4. What factors aggravate your symptoms?
5. Does your problem have a negative impact on your work performance sex life quality of life social activities
6. Do you use any medications or other substances to help you sleep?
7. Do any members of your family have significant sleep-related problems?
8. Have you discussed your sleep-related problems with another doctor?
Doctor's Name: Diagnosis:
Current treatment: Prior treatment:

Please rate how often you or others note that you:

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>
Snore	_____	_____	_____
Snore loudly enough for others to complain	_____	_____	_____
Awaken from sleep feeling short of breath, gasping, or choking	_____	_____	_____
Hold your breath or stop breathing while asleep	_____	_____	_____
Experience other breathing problems at night	_____	_____	_____
Wake up with a headache that improves in less than 2 hours	_____	_____	_____
Have dry mouth upon awakening	_____	_____	_____
Sweat excessively at night	_____	_____	_____
Experience heart pounding or irregular heart beats during night	_____	_____	_____
<hr/>			
Feel sleepy or tired during the day	_____	_____	_____
Awaken feeling unrested or unrefreshed	_____	_____	_____
Become drowsy while driving	_____	_____	_____
Have motor vehicle accidents due to sleepiness	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____
Become irritable or crabby	_____	_____	_____
Have difficulty concentrating; experience memory impairment	_____	_____	_____
<hr/>			
Fall asleep involuntarily, suddenly or in an awkward situation	_____	_____	_____
Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations	_____	_____	_____
Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness	_____	_____	_____
<hr/>			
Have nightmares or night terrors	_____	_____	_____
Act out dreams by yelling and swinging arms and legs	_____	_____	_____
Walk or talk while asleep	_____	_____	_____
Do anything else considered "unusual" while asleep	_____	_____	_____
<hr/>			
Move, twitch or jerk your legs while asleep	_____	_____	_____
Feel leg restlessness, agitation or discomfort at or before bedtime	_____	_____	_____
If yes: Do you feel an overwhelming urge to move your legs?		Yes	No
Does it happen only in the evening?		Yes	No
Does it only happen when you are relaxed?		Yes	No
Does it get better if you move around or walk?		Yes	No
Does it disturb your sleep or sleep onset?		Yes	No
How often do you experience this feeling? _____			

Sleep Hygiene

1. Do you often have anxiety around bedtime? Yes No
2. Do you have thoughts racing through your mind while trying to fall asleep? Yes No
3. Do you sleep better away from home than in your own bed? Yes No
4. Are you anxious or upset if you have difficulty falling asleep? Yes No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? Yes No
6. Do you exercise within 2 hours of your bedtime? Yes No
7. Do you watch TV or read in bed before falling asleep? Yes No
8. Do you ever nap or rest during the awake portion of your day? Yes No
If yes: How often? _____ times per day; _____ times per week
How long is your nap / rest? < one hour one hour
After the nap / rest, do you still feel tired? Yes No
9. Check conditions that routinely apply to you: Sleep alone Sleep with someone else in bed
Sleep with pet in room/bed Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: Heat Cold Light Noise Bed Partner
Other: _____

Sleep Habits

1. When do you feel your very best? Morning Afternoon Evening
2. Approximately, how many hours do you actually sleep per night? _____
3. What time do you usually go to bed? Workdays: _____ Non-Workdays: _____
4. What time do you usually rise from bed? Workdays: _____ Non-Workdays: _____
5. How long does it usually take for you to fall asleep? _____
6. How many hours of sleep do you need to feel your very best? _____
7. In an perfect world, what would be the ideal hour for you to go to bed? _____
8. In an perfect world, what would be the ideal hour for you to awaken? _____
9. What usually prevents you from quickly falling asleep? _____
10. How many times do you typically wake up during the night? _____
11. What generally causes you to wake up during the night? _____
12. If you wake up during the night, how long do you typically stay awake? _____
13. If you wake up during the night, when do you typically wake up?
Soon after falling asleep In the middle of the night Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _____

MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

Angina Congestive heart failure Coronary artery disease Arteriosclerosis Heart murmur Rheumatic heart disease Arrhythmia Hypertension Stroke Peripheral artery disease Other cardiovascular disorders _____ Asthma Bronchitis Emphysema Sinusitis Other respiratory disorders _____	Acid reflux Diverticulitis Hiatal hernia Swallowing disorder Stomach ulcers Other gastrointestinal disorders _____ Arthritis Back pain Osteoporosis Chronic fatigue syndrome Fibromyalgia Autoimmune disorder Neuromuscular disorder Diabetes Sickle cell anemia Thyroid disease Cancer	Migraines Seizures / Epilepsy Brain infection Brain injury Spinal infection Spinal injury Nerve injury Other neurologic disorders _____ Liver disease Kidney disease Blood disorder Depression Anxiety / Panic attacks Alcoholism Drug abuse Other psychiatric disorders _____
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Current Medications: Please list all medications that you are currently taking and their dosages:

Drug Allergies: Are you allergic to any drugs? Yes No If yes, please list:

Past Surgeries: Please list all operations and the approximate date of the procedure. _____

Family History: Has anyone in your blood-related family been afflicted with the following conditions:

Hypertension	Diabetes	Heart disease	Stroke	Cancer	
Sleep apnea	Narcolepsy	Restless legs syndrome	Sleep walking / talking	Parasomnias	

Occupational History: Occupation: _____ Are you a shift worker? Yes No If yes, please describe work schedule: _____

Social History

Marital Status:	Single	Married	Divorced	Widowed	
Children living at home:	No	Yes	Ages of children: _____		
Others living at home:	No	Yes	Spouse	Parents / Grandparents	Friend
Alcohol consumption:	Never	Rarely	Occasionally	Frequently	Alcoholic
Tobacco use	No	Yes	If yes, Type: _____		Frequency: _____
Recreational drug use	No	Yes	If yes, Type: _____		Frequency: _____

REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

General

Fatigue
Malaise / lethargy
Generalized weakness
Loss of appetite
Weight loss
Weight gain
Night sweats
Fever / chills

Eyes

Vision changes
Double vision
Discharge
Pain
Sensitivity to light

Gastrointestinal System

Nausea / vomiting
Indigestion
Acid reflux
Diarrhea
Constipation
Cramps
Bloating
Vomiting blood
Blood in stool
Abdominal pain
Abdominal swelling
Rectal pain
Rectal bleeding

Psychiatric Symptoms

Depression
Anxiety / panic attacks
Hallucinations
Delirium
Dementia
Suicidal ideation

Ears, Nose, Throat and Mouth

Earache
Ringing in the ears
Allergies
Frequent colds
Nasal congestion
Nosebleeds
Sinusitis
Toothache
Oral ulcers
Dry mouth
Facial pain
Jaw pain
Hoarse voice
Sore throat
Difficulty swallowing
Swollen glands

Genitourinary System

Frequent urination
Painful urination
Urinary incontinence
Blood in urine
Pelvic / groin pain
Genital ulcers
Male:
Erectile dysfunction
Testicular pain / swelling
Female:
Irregular periods
Hot flashes
Vaginal discharge

Endocrine System

Heat intolerance
Cold intolerance
Excessive thirst
Sexual dysfunction
Hair loss
Excessive sweating

Cardiovascular System

Chest pain
Pain in arm, shoulder, jaw,
neck or back
Rapid heart rate
Irregular heartbeat
Dizziness
Pain in leg when walking
Ankle / leg swelling

Lungs

Chronic cough
Shortness of breath
with mild exertion
Difficulty breathing
Wheezing
Bloody sputum

Musculoskeletal System

Joint pain / swelling
Back pain
Muscle pain / weakness
Leg cramps

Nervous System

Headaches / migraines
Dizziness / fainting
Seizures
Tremors
Disorientation
Lack of coordination
Numbness / paralysis
Memory loss / impairment

Skin

Rashes
Bruises
Hives
Lesions

Patient's Signature _____

Date _____



EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

Age: _____ Male Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 - Would **never** doze
- 1 - **Slight chance** of dozing
- 2 - **Moderate chance** of dozing
- 3 - **High chance** of dozing

It is important that you answer each question as best you can.

SITUATION (0-3)

CHANCE OF DOZING

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (e.g., a 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 _____

Sitting quietly after a lunch without alcohol _____

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

Total score: _____



BED PARTNER QUESTIONNAIRE

Observer's Name: _____ Relationship to Patient: _____ Date: _____

Frequency of observations: Once or twice Often Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

- | | |
|--|--------------------------------|
| Light snoring | Sleep talking |
| Loud snoring | Sitting up in bed not awake |
| Loud snorts | Getting out of bed not awake |
| Pause in breathing (How long? ____seconds) | Head rocking or banging |
| Choking | Awakening with pain |
| Gasping for air | Becoming very rigid or shaking |
| Twitching, moving or kicking of legs | Biting tongue |
| Twitching or flinging of arms | Crying out |
| Grinding teeth | |
| Apparently sleeping even if person behaves otherwise | |
| Other _____ | |

If person snores, what makes snoring worse?

Sleeping on back Sleeping on side Alcohol Fatigue

Does snoring sometimes require you or your partner to sleep separately? Yes No

Does this person drink alcohol or use street drugs? Yes No



Welcome to Sleep Centers of Texas!

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. Sleep Centers of Texas is a full-service, state-of-the art facility dedicated to providing you with the highest quality of care in sleep medicine. We are committed to working closely with you and with your physician or dentist to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our administrative and financial policies.

OFFICE HOURS

Our normal business hours are Monday through Friday 8:30 A.M. to 5:00 P.M. For assistance after normal hours regarding the home sleep apnea test or use of the PAP device, please call 210.378.9014. For all other matters, please leave a message on the voicemail and we will return your phone call within 12-24 hours.

SCHEDULING APPOINTMENTS

Office visits for initial examinations, consultations, PAP device delivery and setup, and follow-up appointments are scheduled during normal business hours; in-laboratory sleep studies are scheduled each night of the week with limited exceptions. Generally test results are available within one week of the sleep study or polysomnography. To schedule an appointment, please call our office during normal business hours.

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, please notify our office during normal business hours at least 24 hours prior to your appointment. By doing so, you will not incur a cancellation fee. However, if you do not cancel and you do not show up for your appointment, a fee of \$35 for daytime appointments and a fee of \$150 for overnight sleep study appointments may be billed to you for which you may be personally responsible. Please bear in mind that for each overnight sleep study a private room is reserved for you and a sleep technologist is assigned to you, so costs are incurred in preparation for your sleep study. Kindly call our office as far in advance as possible should you need to reschedule your appointment.

CONFIDENTIALITY OF MEDICAL RECORDS

Sleep Centers of Texas is committed to protecting the privacy of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control the information. All records that we create or receive concerning your health or medical condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

RECORDS REQUESTS

To authorize release of your medical information to a specific person / entity, or to request a personal copy of your own medical records, please submit your request in writing to our Compliance Officer. By law, we are required to retain your medical records for 7 years. For forms, such as short-term disability forms or creditor forms, which you request that our office staff complete on your behalf, please allow our staff 48 hours to respond to your request. We charge \$35 per form.

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. Sleep Centers of Texas accepts most major insurance carriers, including Medicare and Medicaid. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are a covered benefit in all insurance policies. In some instances, you may be responsible for amounts not covered by the contract. We will make every effort to determine, and disclose to you, whether our services are covered by your insurance plan before the diagnostic test or treatment is provided. If you have any questions or are uncertain as to your insurance coverage, please feel free to contact us for assistance.

Payment Options

- **Insured Patients:** We require that you present a current copy of your insurance card to the receptionist at the time of service. You must pay all deductibles, copayments and coinsurance in full at the time of service. You may choose to pay with cash, check, or credit card. Although we may estimate the portion that your insurance carrier will pay, it is your insurance carrier that makes the final determination of eligibility and payment. Once your claim is processed by your insurance carrier, any amounts not covered by your insurance will be billed to you and it is your obligation to pay the charges.
- **Private Pay / Uninsured Patients:** If you do not have insurance coverage or your insurance carrier declines to cover a specific service, if Sleep Centers of Texas is not contracted with your insurer, or if you are paid directly by your insurance carrier, you are expected to pay in full for services rendered at the time of service. In some instances, payment arrangements may be made prior to date of service. If prearranged payments are approved, we will require a valid credit card on file.

Refunds: If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

Returned Checks: There will be a returned check fee of \$20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment. Future visits will need to be paid in cash.

Account Balances: If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

Workers' Compensation / Personal Injury: We do not accept workers' compensation or personal injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time of service.

Disputes: Any disputes of your account should be submitted in writing within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 days of receipt of your written dispute.

COMPLAINTS AND GRIEVANCES

To file a complaint or grievance, kindly fill out our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your grievance.



PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT'S RIGHTS

- The patient has the right to be treated with dignity and considerate, respectful care.
- The patient has the right to impartial access to care regardless of race, gender, religion, national origin, cultural, socioeconomic, or educational background, physical handicap, or ability to pay.
- The patient has the right to emergency care without discrimination due to economic status or payment source.
- The patient has the right to know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- The patient has the right to personal privacy and confidentiality of all records and communications concerning his/her medical history and treatment to the extent of the law.
- The patient has the right to receive relevant and timely information in a manner that is easily understandable concerning his/her diagnosis, treatment, risks and benefits of treatment, prognosis, plan for follow-up care, unanticipated outcomes of care, reasonable alternatives to proposed care, and consequences of non-treatment.
- The patient has the right to discuss and request additional information relating to specific procedures and/or treatments, including associated risks and benefits and alternative procedures and/or treatment.
- The patient has the right to inspect his/her medical record, have information explained or interpreted as necessary, request an amendment to, or receive an accounting of, disclosures regarding his/her personal health information, and for a reasonable fee, receive a copy of the medical record.
- The patient has the right to know the identity of the physicians, nurses, and other healthcare providers who are providing medical services and responsible for his/her care.
- The patient has the right to request information on the existence of business relationships between the health care provider and other health care facility, educational institution, or payers that may influence treatment.
- The patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in the experimental research.
- The patient has the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- The patient has the right to receive, prior to treatment, a reasonable estimate of charges for the treatment.
- The patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- The patient has the right to receive care in a safe setting, free of all forms of abuse or harassment.
- The patient has the right to file a grievance or complaint regarding violation of his/her rights or any concerns regarding the quality of care received. To file a grievance or complaint, the patient is requested to complete and submit the Complaint Form to the Office Manager. Within 14 days of submission of the Complaint Form, the patient will receive written notice of the steps taken on his/her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the grievance or complaint.

PATIENT'S RESPONSIBILITIES

- The patient is responsible for providing, to the best of his/her knowledge, accurate and complete information concerning his/her medical history, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- The patient is responsible for reporting unexpected changes in his/her condition to the health care provider.
- The patient is responsible for reporting whether he/she comprehends the contemplated course of action and what is expected of him/her.
- The patient is responsible for following the recommended plan of treatment.
- The patient is responsible for keeping his/her appointments and, when he/she is unable to do so for any reason, for notifying the health care facility.
- The patient is responsible for his/her actions if treatment is refused or the health care provider's instructions are not followed.
- The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- The patient is responsible for adhering to the facility's rules and regulations regarding patient conduct, being considerate of the rights of other patients and facility personnel, and respectful of the personal property of the other patients and facility personnel as well as the property of the health care facility.