ANCHORAGE SLEEP CENTER

510 W. Tudor, Suite 5
Anchorage, AK 99515
Phone: (907) – 743-0050
Fax: (907) – 743-0060

Patient Information

Patient Demographics:

Last Name:_____ First Name:_____ Middle Initial: _____
Mailing Address:_____
City:_____ State:_____ Zip Code: _____
Home Phone#:_____Work Phone#:_____Cell Phone#:_____
E-mail:_____ Sex: ☐ M ☐ F
Date of Birth:_____ Social Security Number:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Spouse/Significant Others Name:_____ Phone#:_____

Employer:_____ Phone#:_____
Address:_____
City:_____ State:_____ Zip Code: _____
Occupation:_____

Emergency Contact Name:_____ Relationship:_____
Phone#:_____

Physician Information:

Referring Source: ☐ Physician ☐ Family ☐ Friend ☐ Other:_____
Referring Physician:_____ Primary Care Physician:_____

Insurance Information:

Primary Insurance:_____
Policy Holder's Name:_____ Date of Birth:_____
ID#:_____ Group#:_____
Your Relationship to Policy Holder:_____

Secondary Insurance:_____
Policy Holder's Name:_____ Date of Birth:_____
ID#:_____ Group#:_____
Your Relationship to Policy Holder:_____

Tertiary Insurance:_____
Policy Holder's Name:_____ Date of Birth:_____
ID#:_____ Group#:_____
Your Relationship to Policy Holder:_____

The above information is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made with this office, in advance. I authorize the physicians and Anchorage Sleep Center, LLC to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Anchorage Sleep Center, LLC.

Signature:_____ **Date:**_____

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CONSENT TO CARE & FINANCIAL RESPONSIBILITY

Consent to Medical Treatment:
I, the undersigned, hereby consent to and permit my attending physician and his/her designees, the Sleep Center and its employees, and all other persons caring for me to provide treatment and care as may be deemed necessary and available to me during my stay in the Sleep Center including, but not limited to tests, examinations, and medical treatment. I understand that my care is under the control of my attending physicians who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as to the result of treatment or examination at Anchorage Sleep Center, LLC.

Authorization to Release Medical Information:
I hereby authorize Anchorage Sleep Center, LLC to disclose all or any part of my record, and any other information in the Center's possession, to any other charges related to my care, including, but not limited to worker's compensation carriers, insurance companies, welfare funds, or my employer. I hereby release Anchorage Sleep Center, LLC from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Anchorage Sleep Center, LLC to furnish requested information excerpts from my record to any insurer, its intermediary or another health care facility to provide continuity of care. Anchorage Sleep Center may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Anchorage Sleep Center, LLC keeps a record of the health care services provided and that I may review my record (a 24-hour notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Anchorage Sleep Center, LLC to correct that record. Except as noted above, Anchorage Sleep Center, LLC will not disclose my record unless I direct them to do so, unless the law authorizes or compels them. I may see my records or get more information about it from the main office of Anchorage Sleep Center, LLC.

Consent to Record Audio/Video:
I understand that during the course of my sleep study, I may be video/audio taped by the sleep technologist. I hereby authorize the use of this video/audio for the sole purpose of medical diagnosis and treatment. This video will not be distributed or shared for any purpose, unless requested under applicable law.

Photographs:
The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment at Anchorage Sleep Center, LLC for purposes of scientific and medical study and research is approved, provided my identity is not revealed. Photographs may include the use of video tapes and television.

Authorization of Payment:
I hereby authorize payment of medical benefits directly to Anchorage Sleep Center, LLC for services rendered to me during the period of my medical/surgical care. I understand that I am financially responsible for any balance not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

Medicare Authorization: ***(FOR MEDICARE PATIENTS ONLY)***
I hereby request that payment of Medicare benefits be made either to me or on my behalf to Anchorage Sleep Center, LLC for services rendered to me by that physician, clinic or supplier. I authorize any holder of Medicare information about me to be released to the Centers for Medicare Services (CMS) and its agents, information needed to determine the benefits payable for related services.

☐ *Check if not applicable* ***Patient Initials_____***

Acknowledgment of Receipt of HIPPA Notice
I understand Anchorage Sleep Center, LLC, the referring physicians and interpreting physicians are a part of an organized healthcare arrangement and these providers may share my health information for treatment, billing and healthcare operations. I have been given the opportunity to review a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that organized healthcare management arrangement has the right to change this notice at anytime. My signature below constitutes my acknowledgement that I have been provided with an opportunity to receive a copy of the Notice of Privacy Practices.

By signing below, I certify that I have read the above information and that I understand its content, my questions have been answered to my satisfaction.

Signature of Patient (Guardian or Parent if a Minor):_____ Date:_____
Relationship to Patient (if signed by a legal representative):_____

Financial Agreement / Patient Responsibilities:
You have the RESPONSIBILITY to:

- *Provide accurate and complete details about your illness, hospitalization, medications and present conditions.*
- *Tell your doctor about any change in your condition or if problems arise.*
- *Tell your doctor or nurse if you do not understand your treatment or what you are expected to do.*
- *Accept financial responsibility for payment of services, pay your bill promptly or to inform Anchorage Sleep Center, LLC if you are unable to pay your bill.*
- *Notify Anchorage Sleep Center, LLC of any changes in healthcare benefits.*

Initials: _____ of Patient (if not a minor)
Initials: _____ of Patient/Guardian or Other: _____ Relationship: _____

PATIENT NAME: _____

ANCHORAGE SLEEP CENTER

Anchorage Sleep Center, LLC
510 W. Tudor, Suite 5
907-743-0050 OFFICE PHONE
907-743-0060 FAX NUMBER

PATIENT AGREEMENT

Anchorage Sleep Center, LLC offers sleep diagnostic and treatment services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We work with your primary care practitioner to coordinate your care.

Following your initial assessment visit(s), we develop a specific plan of care for review and approval by your referring provider. Once your referring provider signs your Treatment Plan, we can begin working with you to improve your health condition. We are pleased to serve your sleep needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

We require certain information from each patient in order to begin your care. The attached forms need to be completed in order for us to get you started as our patient. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything.

Each healthcare insurance payer has different guidelines for allowing coverage of sleep services. It is helpful if you let us know your healthcare payer when starting service so that we may find out if prior authorizations are needed. If you are a Medicaid beneficiary, please ask your primary care provider to send us a referral for your initial assessment to fulfill Medicaid requirements. If your healthcare insurance payer does not cover sleep medicine services, you are welcome to make self pay arrangements for the usual and customary pricing of our services.

PRESCRIPTIONS

We do not issue prescriptions for medications. We are glad to coordinate your care through your primary care provider who has the ability to write prescriptions for you. If you feel you would benefit from the use of prescription medications, please talk with our therapist for assistance.

NO SHOW POLICY

If you cannot make it to a scheduled appointment, please contact our office at least 24 hours in advance. A charge of $250.00 will be assessed to patient accounts for missed appointments without prior notice. This charge will not be billed to your healthcare insurance payer and is the responsibility of the patient (or parent) to pay.

WAIT LIST FOR SERVICES

If you would like to reschedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment, we will contact patients on the waiting list on a first come, first call basis.

WORKER'S COMPENSATION

If you are being treated for a work related condition, please complete our worker's compensation verification form so that we may submit needed authorizations and claims on your behalf.

MEDICARE, MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES AND NON-COVERED SERVICE

Medicare has a limit on the amount of sleep services they pay for. Once you have exceeded the financial limit of your Part B benefits, and you do not have additional healthcare coverage, you are responsible for the payment of your services. Additionally, Medicare and private healthcare insurance payers have deductible and co-payments for sleep medicine services that are the responsibility of the patient.

BILLING AGENT CONTACT INFORMATION

Our practice uses a professional billing service to process your claims to healthcare payers and to arrange payment of patient balances. We have all the required agreements in place to insure that your protected health information is safe and remains confidential. If you have inquiries about your healthcare claims, monthly statements, or if you have additional billing information, you may reach our billing agent at:

Anchorage Sleep Center, LLC
907-743-0050

INTEREST CHARGES ON PATIENT BALANCES

Our practice charges interest on unpaid account balances. If we receive payment from on your account from either you or your healthcare insurance payer within 30 days, no interest charges will be applied to your account.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

New patients approved for sleep services are responsible for any and all charges not paid for by healthcare insurance payers (Medicare, Medicaid, Private Health Insurance Carriers, Worker's Compensations, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Anchorage Sleep Center, LLC for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, and credit cards VISA, Mastercard, we also make credit card pre payment arrangements for anticipated monthly patient balances. We also are willing to make reasonable payment arrangements to keep your account current. Please contact our Billing Office at 907-743-0050.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either by phone or in writing. Our Manager/Business Owner will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Anchorage Sleep Center, LLC to provide me sleep services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

Signature of Patient or Personal Representative: (Or Witness if signature is by mark)	Date:
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:	

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24-HOUR CANCELLATION POLICY

Due to the nature of overnight sleep studies, it is necessary to make individual reservations for sleep studies. The following policy assures our ability to maintain availability of therapy, appropriate staffing, and timely service.

- For daytime appointments, please arrive fifteen minutes early to register and fill out paperwork.
- If you are more than 10 minutes late for any appointment, you may be asked to reschedule your appointment.
- If you must cancel or change your appointment for any reason, please do so at least **24-hours** in advance of your scheduled arrival time.
- For overnight appointments, there will be a non-refundable **two hundred-fifty dollar ($250)** charge if you miss your appointment without a **24-hour** notice. Please understand this charge is not covered by insurance.
- As a courtesy, we will attempt to confirm your appointment by telephone two to three days prior to your appointment. If we are unable to do so, please feel free to call to confirm your appointment at (907) 743-0050.

All cancellations and issues associated with appointments should be directed to Anchorage Sleep Center, LLC, (907) 743-0050. Business hours are Monday - Friday, 9:00am - 5:00pm.

Thank you for your cooperation,

Anchorage Sleep Center, LLC.

ANCHORAGE SLEEP CENTER

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

PATIENT NAME:	SSN:
AKA NAME(S):	DATE OF BIRTH:

PEOPLE & ENTITIES I AUTHORIZE TO RECEIVE MY PROTECTED HEALTH INFORMATION	
NAME OF ENTITY	**CONTACT INFORMATION**
ANCHORAGE SLEEP CENTER, LLC	510 W. TUDOR RD., SUITE 5, ANCHORAGE, AK 99503 Fax 907-743-0060

Please list medical practitioner(s), spouse, caregiver(s), guardian(s), etc. you are authorizing to receive PHI.

The purpose of this release of protected health information authorization:
I hereby authorize the use or disclosure of my health care and/or other information within my patient record to the entities stated above. I understand that this authorization is voluntary. I understand that my records may contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section at the bottom of this form, or by notifying Anchorage Sleep Center, LLC in writing, but if I do, it will not affect actions taken on this authorization before my revocation was received. I understand that Anchorage Sleep Center, LLC will not condition my treatment, payment, or eligibility for services based on whether I provide this authorization.

I understand that if the person(s) or entities I authorize to receive my protected health information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipients of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.

This authorization expires on the following date or event:
Signature of Patient or Personal Representative: Date (Or Witness if signature is by mark)
Printed Name of Personal Representative or Witness Description of Personal Representative's Authority:
NOTE: This authorization was revoked on: _____ (see attached revocation). Complete when/if revoked. Date

A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

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SLEEP SURVEY

Patient Name: _____ (Last) _____ (First) _____ (Middle Initial) **Today's Date:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Referring Physician:** _____

What is your main sleep complaint? _____

Sleep Habits:

1. **What time on weekdays do you usually?** **Go to bed:** _____ **Wake up:** _____
2. **What are your usual working hours if applicable?** **Begin:** _____ **End:** _____
3. **What time on weekends do you usually?** **Go to bed:** _____ **Wake up:** _____
4. **On average, how long do you actually sleep at night?** **Weekdays:** _____ **Weekends:** _____
5. **Do you feel that you get too much or too little sleep at night?** **Too much:** _____ **Too Little:** _____

Nighttime Symptoms:

6. **How long does it normally take you to fall asleep at night?** **Minutes:** _____
7. **Do you have thoughts that prevent sleep?** **Yes:** ☐ **No:** ☐
8. **Do you have trouble getting to sleep at night?** **Yes:** ☐ **No:** ☐
9. **Do you awaken at night to use the bathroom?** **Yes:** ☐ **No:** ☐ **How often?** _____
10. **Are you ever awakened by a "coughing spell" during the night?** **Yes:** ☐ **No:** ☐
11. **Do you have crawling sensations in your legs while falling asleep?** **Yes:** ☐ **No:** ☐
12. **Do you have twitching movements in your legs during the night?** **Yes:** ☐ **No:** ☐
13. **Do you awaken with racing thoughts, sadness or anxiety?** **Yes:** ☐ **No:** ☐
14. **Have other people told you that you have restless sleep?** **Yes:** ☐ **No:** ☐
15. **Do you have difficulty going back to sleep during the night?** **Yes:** ☐ **No:** ☐
16. **Does anyone tell you that you snore badly?** **Yes:** ☐ **No:** ☐
17. **Do you have difficulty breathing at night?** **Yes:** ☐ **No:** ☐
18. **Do you wake up with headaches?** **Yes:** ☐ **No:** ☐ **How often?** _____
19. **Do you awaken with a sour or bitter taste in your mouth?** **Yes:** ☐ **No:** ☐ **How often?** _____
20. **Is it difficult for you to awaken and get out of bed after sleeping?** **Yes:** ☐ **No:** ☐ **How often?** _____
21. **Have you experienced paralysis upon awakening from sleep?** **Yes:** ☐ **No:** ☐ **How often?** _____
22. **Do you have vivid dreams as you are falling asleep?** **Yes:** ☐ **No:** ☐ **How often?** _____
23. **Is your sleep disturbed by a medical problem?** **Yes:** ☐ **No:** ☐
    If "yes" describe: _____

Daytime Symptoms:

24. **Do you deliberately take naps during the day?** **Yes:** ☐ **No:** ☐
    If "yes": **How often?** _____ **How long?** _____
25. **Do you feel rested after a nap?** **Yes:** ☐ **No:** ☐
26. **Are you bothered by sleepiness during the day?** **Yes:** ☐ **No:** ☐ **How often?** _____
27. **Do you find yourself falling asleep when you don't mean to?** **Yes:** ☐ **No:** ☐ **How often?** _____

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28. **How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.**

(0 = no chance of dozing, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing)

Sitting and reading:	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV:	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (ex. theater or meeting):	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break:	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit:	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone:	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol:	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic:	☐ 0	☐ 1	☐ 2	☐ 3

TOTAL: ☐

29. **Have you noticed, or been told about, any changes in your personality recently such as:**

Irritability:	☐ Yes	☐ No	**Loss of concentration:**	☐ Yes	☐ No
Increased temper:	☐ Yes	☐ No	**"Spaced out" feeling:**	☐ Yes	☐ No
Anxiety:	☐ Yes	☐ No	**Decreased job productivity:**	☐ Yes	☐ No
Depression:	☐ Yes	☐ No	**Poor memory:**	☐ Yes	☐ No

30. **Have you ever had the following kinds of weakness develop suddenly during an emotional situation (ex. when laughing, angry, in an exciting situation, etc.)?** *(Check one on each line)*

Knees buckling:	☐ Never	☐ 1-5 times in your life	☐ Monthly	☐ Weekly	☐ Daily
Mouth opening:	☐ Never	☐ 1-5 times in your life	☐ Monthly	☐ Weekly	☐ Daily
Head nodding:	☐ Never	☐ 1-5 times in your life	☐ Monthly	☐ Weekly	☐ Daily
Falling down:	☐ Never	☐ 1-5 times in your life	☐ Monthly	☐ Weekly	☐ Daily

31. **Do you know, or do others tell you that you:**

	Age Started	*Last Occurred*	*Frequency*	*Treatment*
Talk while asleep:				
Walk while apparently asleep:				
Grit teeth while apparently asleep:				
Wake up screaming, anxious or afraid:				
Have disturbing dreams (nightmares):				
Have unusual movements while asleep:				

32. **Please write the average amount of each listed beverage you drink daily:**
Coffee (cups): ☐ **Hot or Iced tea (cups):** ☐ **Caffeinated soft drinks:** ☐

33. **Do you smoke cigarettes?** ☐ **Yes** ☐ **No**
If "yes": **How many packs per day?** ☐ **For how many years?** ☐

34. **How many alcoholic beverages do you drink:** **On weekdays** ☐ **On weekends** ☐ **or per month** ☐

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Health History: *(please check all that apply)*

- ☐ **Weight problems**
- ☐ **High blood pressure**
- ☐ **Shortness of breath**
- ☐ **Deviated nasal septum**
- ☐ **Sinus problems**
- ☐ **Tonsillectomy**
- ☐ **Sinus surgery**
- ☐ **Chronic cough**
- ☐ **Chronic bronchitis**
- ☐ **Asthma**
- ☐ **Emphysema**
- ☐ **Lung disease**
- ☐ **Ulcers**
- ☐ **Colitis**
- ☐ **Kidney problems**
- ☐ **Thyroid disorder**
- ☐ **Diabetes**
- ☐ **Heart disease**
- ☐ **Neurologic disease**
- ☐ **Anxiety**
- ☐ **Dementia**
- ☐ **Depression**
- ☐ **Psychiatric problems**
- ☐ **Stroke**
- ☐ **Cancer**
- ☐ **Narcolepsy**
- ☐ **Chronic fatigue**
- ☐ **Fibromyalgia**
- ☐ **Parkinson's**

Surgical/Hospitalization History: *(please list any surgeries or hospitalizations and their dates)*

Surgeries	Date	Hospitalization	Date

Current Medications: *(please list any and all current medications)*

Medication *(ex. aspirin)*	**Strength** *(ex. 81mg)*	**Dosage** *(ex. once daily)*

35. **If anyone in your family has had sleep problems please list the problem and your relationship:**

36. **If there are any other aspects that you feel are important please describe them here:**

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BED PARTNER QUESTIONNAIRE

Name of Patient:_____ **Date:**_____

Name of person completing this questionnaire:_____

- I have observed this person's sleep: ☐ Never ☐ Once or Twice ☐ Often ☐ Every night
- Check any of the following behaviors you have observed this person doing while sleeping:

☐ Light snoring
☐ Loud snoring
☐ Head rocking or banging
☐ Choking
☐ Pauses in breathing
☐ Occasional loud snorts
☐ Getting out of bed but not awake
☐ Twitching or kicking of arms during sleep
☐ Bedwetting
☐ Twitching or kicking of legs during sleep
☐ Crying out
☐ Sitting up in bed not awake
☐ Biting tongue
☐ Sleepwalking
☐ Grinding teeth
☐ Very rigid/shaking
☐ Other:_____

- If this person snores, what makes it worse? ☐ sleeping on back ☐ sleeping on side ☐ alcohol ☐ fatigue
- Does the snoring sometimes require you and your partner sleep separately? ☐ Yes ☐ No
- Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night._____

_____

- Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

  if yes, please explain:_____
- Does this person use sleeping pills? ☐ Yes ☐ No

  if yes, how many times per week? ☐ less than one ☐ 1-3 ☐ 4-6 ☐ Every night
- Do you consider this usage a problem? ☐ Yes ☐ No

  Comments:_____
- Does this person drink alcohol? ☐ Yes ☐ No If so, what type? ☐ Beer ☐ Wines ☐ Liquor

  Estimate how many drinks per day/week: _____/_____ 12oz. beer _____/_____ 6-8 oz. wine _____/_____ 1 oz. liquor
- Estimate how much this person drinks three hours before bed:_____
- Do you consider this persons drinking a problem? ☐ Yes ☐ No ☐ Uncertain

  Comments:_____
- If this person uses recreational drugs, please describe the type and frequency of usage:_____

_____
- Do you believe that this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage and alcohol/drug usage? ☐ Yes ☐ No

  Comments:_____

ANCHORAGE SLEEP CENTER

PRIVACY PRACTICES

As required by privacy regulations created as a result of the Health Insurance Portability/Accountabilty Act of 1996, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE READ CAREFULLY.
Within this document the patient is referred to as "you". If you are a parent or legal guardian of the patient, reading this notice will inform you of the clinic's policies regarding your child's medical information and how it will be handled.

Commitment to Privacy:
This clinic is committed to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of your health information. We also are required by law to provide you with this notice of our legal cuties and privacy practices that we maintain in this clinic concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We recognize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure regarding your PHI.

We May Use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. Treatment – This clinic may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other providers, caseworkers, and school related personnel.
2. Payment – This clinic may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. Health Care Operations – This clinic may use and disclose your PHI to operate our business. An example of this is, using your PHI to evaluate the quality of care you receive from us.
4. Appointment – This clinic may use and disclose your PHI to contact you and remind you of an appointment. An example of this is, leaving a message on your answering machine.
5. Release of Information to Family/Friends – This clinic may release your PHI to a friend or family member that is involved in your care. For example, if a friend, babysitter, grandparent, or other family member brings you or your child to the clinic for care, they will receive medical information about you or that child.
6. Disclosures Required by Law – This clinic will use and disclose your PHI when we are required to do so by federal, state, and/or local law.

Uses and Disclosure of your PHI in Certain Special Circumstances:

1. Public Health Risks – This clinic may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or device they may be using has been recalled, or notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. Health Oversight Activities – This clinic may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings – This clinic may use and disclose your PHI in response to a court order, if you are involved in a lawsuit or similar proceedings.
4. Law Enforcement – This clinic may release PHI if asked to do so by a law enforcement official regarding a crime victim. If we are unable to obtain the person's agreement, concerning what we believe has resulted from criminal conduct, regarding criminal conduct at our offices, in response to a warrant, summons, court order, or similar legal process, to identify/locate a suspect, material witness, fugitive or missing person, or in an emergency, to report a crime.
5. Serious Threats to Health and Safety – This clinic may use and disclose your PHI when necessary to reduce or prevent a serious threat to you or your child's health and safety or the health and safety of another individual.
6. Military – This clinic may disclose your PHI if you are a member of US or foreign military forces and if required by the appropriate authorities.
7. National Security – This clinic may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. Inmates – This clinic may disclose your PHI to correctional institutions or law enforcement officials if you or your child is an inmate or under the custody of law enforcement officials. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.
9. Worker's Compensation – This clinic may release your PHI for workers' compensation and similar programs.

Your Rights Regarding Your PHI:
You have the following rights regarding the PHI that we maintain about you or your child. Request involving your rights must be submitted in writing.

1. Confidential Communications – You have the right to request that our clinic communicate with you about health related issues in a particular manner, or at a certain location. The request must specify the method of contract, or the location where you wish to be contracted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Restrictions – You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our clinic's use, disclosure or both, and to whom you want the limits to apply.
3. Inspection and Copies – You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records, and billing records. This clinic may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. Amendment – You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for this clinic. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to amend information that is in our opinion accurate and complete, not part of the PHI, not created by our clinic, or the individual/entity that created the information is not available to amend the information.
5. Accounting of Disclosure – All of our patients have the right to request on "accounting of disclosures" which is a list of certain non-routine disclosures our clinic has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 15, 2003.
6. Right to a Paper Copy of this Notice – You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. Right to File a Complaint – If you believe your privacy rights have been violated, you may file a complaint with this clinic's privacy officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. Right to Provide an Authorization for Other Uses and Disclosure – This clinic will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of you or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in this authorization. Please note we are required to retain records of your care.

This clinic reserves the right to revise or amend the Notice of Privacy Practices. Any revisions to this notice will be effective for any records that this clinic has created or maintained in the past or will create or maintain in the future.

Effective October 1, 2010

ANCHORAGE SLEEP CENTER

510 W. Tudor, Suite 5
Anchorage, AK 99515
Phone: (907) – 743-0050
Fax: (907) – 743-0060

What to Expect

Certain sleep disorders require an overnight observation in our sleep center. The overnight sleep study is a non-invasive, painless evaluation of your sleep. During the overnight sleep study (polysomnogram), brainwave activity, eye movements, muscle contractions, heart activity, breathing, and blood oxygenation will be measured.

On the night of your study you will be asked to report to the sleep center between 8:00pm and 9:30pm to prepare for your sleep study.

HOW TO PREPARE:

- Avoid napping the day of your sleep study
- Avoid alcohol, caffeine, sedatives, and stimulants 24 hours prior to your study
- Eat your regular evening meal before you arrive at the sleep center
- On the day of the study, be sure that your hair is free of oil, hair spray, and other products
- Bring comfortable sleep attire
- Bring any and all necessary forms and paperwork
- Bring your regularly scheduled medications and plan to take them as you normally would unless your physician instructs otherwise
- If you are under 18 years of age, a parent or guardian is required to stay with you in the sleep center
- Notify us if you have a disability that requires special assistance and we will be happy to accommodate your needs

COMMON QUESTIONS:

"What should I bring to my sleep study?"

- Pack as you would for an overnight stay in a hotel or spa. For the benefit of your comfort and privacy, please bring appropriate and comfortable sleep attire (ie. night gown or pajamas). We have bathroom and shower facilities available for your convenience.

"What if I'm running late for my sleep study?"

- Please contact our lab directly at (907) 743-0050 and let us know what time you expect to arrive.

"What happens when I arrive at the sleep center for my study?"

- Sleep studies usually begin in the late evening and end at about 5:30am-6:30am the following day. Once you arrive at the center, one of our wonderful sleep technologists will welcome you and show you to your private bedroom. The technologist will verify that all necessary forms are completed and answer any questions you may have.

"Will I have my own room?"

- Yes, our sleep study bedrooms are private.

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"Will I be able to sleep with the monitoring equipment attached to me?"

- Most people do not find it uncomfortable at all, nor an obstacle to falling asleep. We make every effort to ensure that you are as comfortable as possible. Should any issues with your comfort arise, your sleep technologist will make adjustments. Your bedroom has an open intercom that will enable you to communicate with your technologist at any time.

"What if I need to go to the bathroom during the study?"

- If you need to use the bathroom at any point during the night, you can call you sleep technologist on the intercom for assistance. They will temporarily disconnect your monitoring equipment to allow you to use the facilities.

"When can I leave the sleep center?"

- Studies are completed between 5:30am-6:30am. You should plan on adding an additional 30 minutes to your morning routine to account for time to allow your sleep technologist to remove the monitoring equipment. You may take a shower to wash away any remaining gels and pastes used with the monitoring equipment. If you need to be ready to leave the center at a certain time, please let us know when you arrive at the center so we can accommodate your request.

"Does the sleep center provide breakfast?"

- The sleep center is set up with a small kitchenette and we will provide a light, complimentary breakfast. Selections may include breakfast bars, oatmeal, coffee, teas, and juices. A refrigerator and microwave are available for your convenience. You are more than welcome to use the kitchenette area or ask your sleep technologist for assistance.

"What happens after my sleep study?"

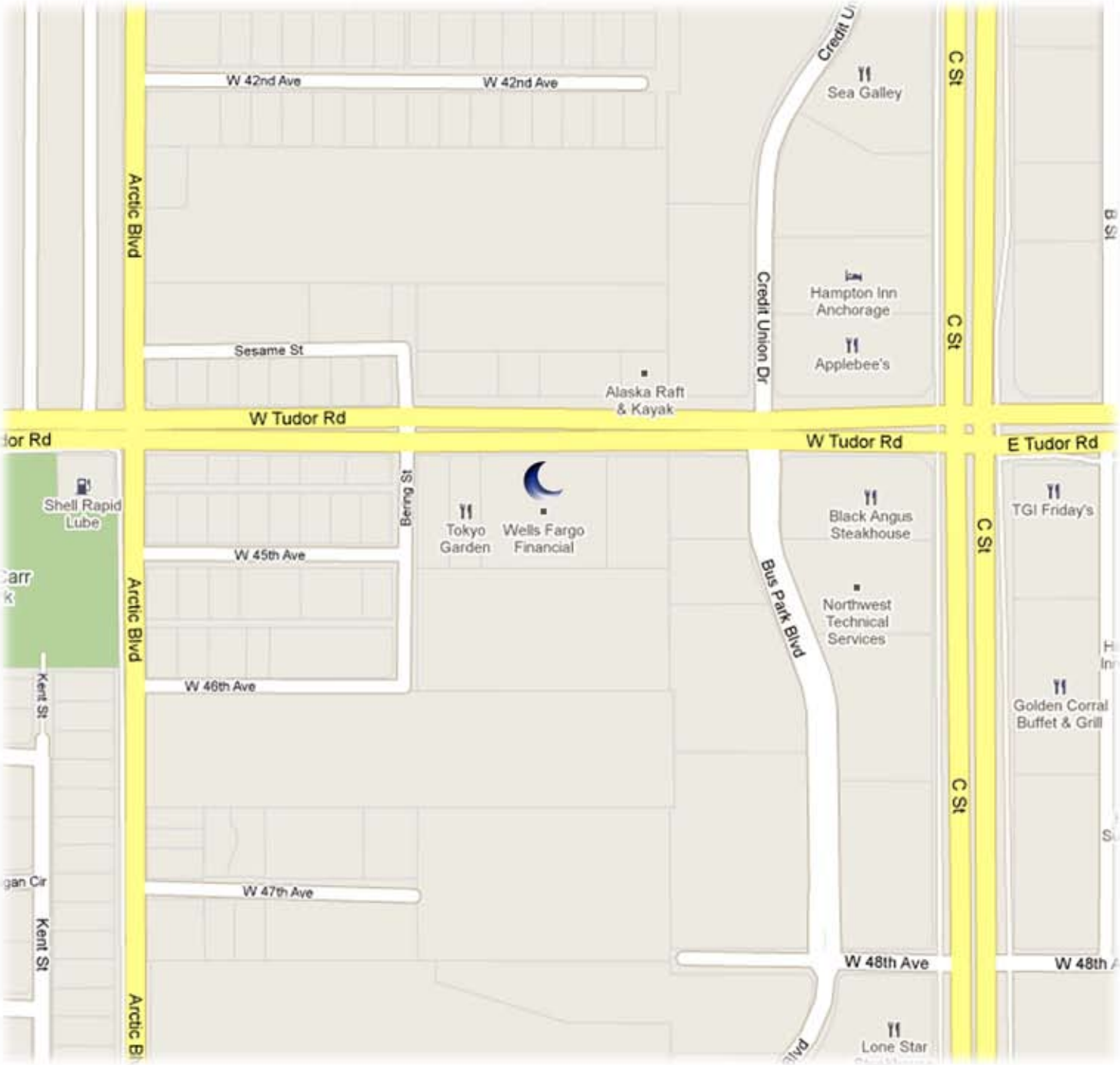
- A large amount of information is collected during your study. This information is reviewed by your sleep technologist, and finally our Medical Director. Once our Medical Director has reviewed the information he creates a formal report that will be sent to your doctor.

"When will my doctor receive my results?"

- It usually takes 2-5 business days for your doctor to receive your formal report.

Once again we would like to say "THANK YOU!" for choosing Anchorage Sleep Center, LLC for your sleep needs!

ANCHORAGE
SLEEP CENTER



Located between Arctic and C street on West Tudor Road.

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