ANCHORAGE SLEEP CENTER | WASILLA SLEEP CENTER | FAIRBANKS SLEEP CENTER | SOUTHEAST SLEEP CENTER

PATIENT INFORMATION

Patient Demographics

Last Name:	First Name:	Middle Initial:
Mailing Address:		
City:	State:	Zip:
Home Phone#:	Work Phone#:	Cell Phone#
Email:		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:
Occupation:		
Emergency Contact Name:	Relationship:	
Phone#:		

Provider Information

Referral Source: ☐ Provider ☐ Family ☐ Friend ☐ Other:	
Referring Provider:	Primary Care Provider:

Insurance Information

Primary Insurance:		
Policy Holder Name:		Date of Birth:
ID#	Group#	
Relationship to Policy Holder:		
Secondary Insurance:		
Policy Holder Name:		Date of Birth:
ID#	Group#	
Relationship to Policy Holder:		
Tertiary Insurance:		
Policy Holder Name:		Date of Birth:
ID#	Group#	
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 of Patient (Guardian/Parent if Minor): _____ *Date:* _____

Relationship to Patient (If legal representative): _____

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SLEEP SURVEY

Patient Name: _____ Referring Provider: _____

Today's Date: _____ DOB: _____ Age: _____ Height: _____ Weight: _____ BMI: _____

Main Sleep Complaint: _____Contact phone: _____

SLEEP HABITS

What time on weekdays do you usually?	Go to bed:	Wake up:	
What time on weekends do you usually?	Go to bed:	Wake up:	
What are your usual work hours *(if applicable)*?	Begin:	End:	
How long does it take you to get to sleep?	Minutes:		
How often do you wake up at night?	Times:		
How long to return to sleep?	Minutes:		
Does anyone tell you that you snore?	☐ Yes ☐ No		
Do you feel rested upon awakening?	☐ Yes ☐ No		
Do you awaken with racing thoughts or anxiety?	☐ Yes ☐ No		
Do you have vivid dreams as you are falling asleep?	☐ Yes ☐ No		
Are you bothered by sleepiness during the day?	☐ Yes ☐ No		
Do you experience crawling sensations in your legs prior to sleep?	☐ Yes ☐ No	How often:	
Do you wake up with headaches?	☐ Yes ☐ No	How often:	
Do you awaken with a bitter or sour taste in your mouth?	☐ Yes ☐ No	How often:	
Do you take a nap during the day? ☐ Yes ☐ No	How long:	How often:	

How likely are you to doze off or fall asleep in the following situations?

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for one hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch *(without alcohol)*	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3
Total Score				

Other concerns: _____

_____

_____

_____

_____

_____

_____

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MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ Goiter
- ☐ Angina
- ☐ Pulmonary embolism
- ☐ Epilepsy *(seizures)*
- ☐ Crohn's disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Cancer *(type)*_____
- ☐ Heart problems
- ☐ Asthma
- ☐ Cataracts
- ☐ Colitis
- ☐ Stomach or peptic ulcer
- ☐ Other _____
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Heart murmur
- ☐ Emphysema
- ☐ Kidney disease
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ Hypothyroidism
- ☐ Psoriasis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Kidney stones
- ☐ Jaundice
- ☐ Tuberculosis

Describe further: _____

_____

_____

_____

_____

Hospital & Surgical History: _____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation: _____

Tobacco? ☐ Yes ☐ No How many packs per day? _____How long? _____

Cannabis? ☐ Yes ☐ No

Average amount of caffeinated beverages per day: Coffee (cups) _____ Tea _____ Soft drinks _____

Average number of alcohol containing beverages per day? Weekdays _____ Weekends _____ Type: _____

Any recreational drug use? _____

Family History: _____

_____

CURRENT MEDICATIONS

Name of drug	Dose (strength & #pills/day)	Name of drug	Dose (strength & #pills/day)

Allergies? ☐ Yes ☐ No *If so please list:* _____

_____

_____

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BED PARTNER QUESTIONNAIRE

Patient Name: _____ 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	☐ Twitching/Kicking	☐ Head rocking/banging	☐ Choking
☐ Loud snoring	☐ Crying out	☐ Sitting up not awake	☐ Pauses in breathing
☐ Biting tongue	☐ Sleepwalking	☐ Occasional loud snorts	☐ Grinding Teeth
☐ Very rigid/shaking	☐ Bedwetting	☐ Getting out of bed not awake	

☐ 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 ☐ Wine ☐ Liquor

Estimate how many drinks per day/week:

Estimate how much this person drinks three hours before bed: _____

Do you consider this persons drinking a problem? ☐ Yes ☐ No

Comments: _____

If this person uses recreational drugs, please describe the frequency of usage: _____

_____

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

Comments: _____

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RELEASE OF INFORMATION

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	510 W. TUDOR RD #5, ANCHORAGE, AK 99503 (FAX) 907-743-0060
WASILLA SLEEP CENTER	3719 E. MERIDIAN LP #C, WASILLA, AK 99654 (FAX) 907-357-4201
FAIRBANKS SLEEP CENTER	475 RIVERSTONE WAY #1, FAIRBANKS, AK 99709 (FAX) 907-374-9930
SOUTHEAST SLEEP CENTER	8800 GLACIER HWY #215, JUNEAU, AK 99801 (FAX) 907-500-7386

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** (Guardian/Parent if Minor)*: _____ ***Date: _____

***Relationship to Patient** (If legal representative)*: _____

**A photocopy of this authorization as valid as the original*

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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 & CANCELLATION 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. All cancellations and issues associated with appointments should be directed to the individual office: Anchorage 907-743-0050 / Wasilla 907-357-4200 / Fairbanks 907-374-9920 / Southeast 907-500-7368. Business hours are Monday-Friday 9:00am – 5:00pm.

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.

BLLING 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 (Guardian/Parent if Minor): _____ *Date:* _____

Relationship to Patient (If legal representative): _____

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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 any time. My signature below constitutes my acknowledgement that I have been provided with an opportunity to receive a copy of the Notice of Privacy Practices.

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.*

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/Parent if Minor):* _____ ***Date: _____

***Relationship to Patient** (If legal representative):* _____

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PRIVACY PRACTICES

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability 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.