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## FINANCIAL POLICY

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We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Your office visit co-pay is due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. Payment for co-insurance (i.e. 20%) and deductibles are due upon receipt of your first statement.

As a courtesy, we will process and file your insurance claims for technical and professional services for you at no cost.

**Returned checks are subject to a handling fee of \$35.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.**

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

If for any reason I default on incurred charges I will be responsible for any collection fees up to fifty percent plus any attorney fees.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

***PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING***

Signature: \_\_\_\_\_  
(Patient and/or Responsible Party)

Date: \_\_\_\_\_



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## Authorization for Use and Disclosure of Protected Health Information

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I, \_\_\_\_\_ hereby give my consent for the Sleep Disorders Center of Alabama to use and disclose protected health information (PHI) about me to provide treatment, payment and healthcare operations (TPO). (The Sleep Disorders Center of Alabama's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

The use or disclosure requested under this authorization **will not** result in direct or indirect remuneration to the Sleep Disorders Center of Alabama from a third party.

I understand that the Sleep Disorders Center of Alabama may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

This authorization shall be in force and effect until \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to inspect or copy the information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), and to revoke this authorization, in writing, at any time by sending such written notification to Denise Franklin at 790 Montclair Road, Suite 200, Birmingham, AL 35213. I understand that a revocation is not effective to the extent that the Sleep Disorders Center of Alabama has relied on the use or disclosure of the protected health information. I understand that my protected health information may include information concerning sexually transmitted diseases and I authorize the release of this information for the purposes stated above. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (or other authority to serve)



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## FORMULARY BENEFITS DATA CONSENT FORM

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Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescriptions drug programs whose primary responsibilities are processing and paying prescriptions drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for The Sleep Disorders Center of Alabama to access my pharmacy benefits data electronically through SureScripts/Community Exchange. This consent will enable The Sleep Disorders Center of Alabama to:

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered under a patient's plan.

Receive notification of a prescription that has been picked up, not picked up, or partially filled by the patient.

Display therapeutic alternatives with preference rank (if available) within a drug class for Non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to pharmacies, and if so, e-prescribe prescriptions to the pharmacy.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information and information about other prescriptions prescribed by other providers using SureScripts/Community Exchange.

**Current Pharmacy:**

Name of Pharmacy: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



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**AUTHORIZATION FOR RELEASE OF INFORMATION**

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\_\_\_\_ **I DO WISH** (WHEN APPLICABLE) TO ALLOW PERSON(S) LISTED BELOW TO CALL/RECEIVE PHONE CALLS, HAVE TEST RESULTS OR OTHER INFORMATION DISCUSSED ON MY BEHALF.

\_\_\_\_ **I DO NOT WISH** TO ALLOW ANYONE BUT MYSELF TO CALL/RECEIVE PHONE CALLS, HAVE TEST RESULTS OR OTHER INFORMATION RELEASED REGARDING MY CARE.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must fill out another Authorization of Release of Information.**

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Authorization for Use and Disclosure of Protected Health Information

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I, \_\_\_\_\_ hereby give my consent for the Sleep Disorders Center of Alabama to use and disclose protected health information (PHI) about me to provide treatment, payment and healthcare operations (TPO). (The Sleep Disorders Center of Alabama’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

The use or disclosure requested under this authorization **will not** result in direct or indirect remuneration to the Sleep Disorders Center of Alabama from a third party.

I understand that the Sleep Disorders Center of Alabama may not condition my treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

This authorization shall be in force and effect until \_\_\_\_\_ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to inspect or copy the information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), and to revoke this authorization, in writing, at any time by sending such written notification to Denise Franklin at 790 Montclair Road, Suite 200, Birmingham, AL 35213. I understand that a revocation is not effective to the extent that the Sleep Disorders Center of Alabama has relied on the use or disclosure of the protected health information. I understand that my protected health information may include information concerning sexually transmitted diseases and I authorize the release of this information for the purposes stated above. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (or other authority to serve)

**Notice of Privacy Practices**

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**The Sleep Disorders Center of Alabama**  
**Notice of Privacy Practices**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

**If you have any questions about this Notice please contact: our Privacy Contact who is**

**Kelly Snyder, Office Manager**

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

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

**1. Uses and Disclosures of Protected Health Information**

**Uses and Disclosures of Protected Health Information Based Upon Your Written Consent**

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

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

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

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



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

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

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

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

### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

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

### **Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.



**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation. *[This section is not applicable to the Sleep Disorders Center of Alabama]*

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

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

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

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

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

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

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

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





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

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

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

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

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

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.



**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

## **2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

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

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **[describe how patient may obtain a restriction.]**

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

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



**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

### **3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Denise Franklin at (205) 599-1020 for further information about the complaint process.

This notice was published and becomes effective on November 18, 2002.



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**Notice of Privacy Practices Acknowledgment**

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I, \_\_\_\_\_, acknowledge I have received a copy of the notice of privacy practices from the Sleep Disorders Center of Alabama.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient (or other authority to serve)

**[If patient or personal representative is unable or refuses to sign the form, document the reasons on this form. Place this form in the patient's medical record.]**