Central Washington Sleep Diagnostic Center, PLLC

603 N. Mission Street
Wenatchee, WA 98801
Phone (509) 663-1578
Fax (509) 663-0174

2323 West Broadway, Suite 4
Moses Lake, WA 98837
Phone (509) 663-1578
Fax (509) 663-0174

520 West Indian Avenue
Brewster, WA 98812
Phone (509) 689-0100
Fax (509) 689-0596

www.cwsleepcenter.com

You have been scheduled for a consultation with
Dr. Eric Haeger / Andrew Swartsel PA-C / Hugh Thomas ARNP / James Peay ARNP
Molly Downey PA-C / Jonathan Henke PA
for sleep related issues.

Your appointment is: ___________________________________

LOCATION OF APPOINTMENT:

Wenatchee
603 N. Mission Street
Wenatchee, WA 98801
Phone (509) 663-1578
Fax (509) 663-0174

Moses Lake
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Brewster
520 West Indian Avenue
Brewster, WA 98812
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Fax (509) 689-0596

OUTREACH CLINIC LOCATIONS:

Lake Chelan Hospital
503 E. Highland Ave, 3rd Floor
Chelan, WA 98816

Mid-Valley Medical Group
529 Jasmine St.
Omak, WA 98841

Coulee Family Medicine
Coulee Medical Arts (old clinic)
411 Fortuyn Road
Grand Coulee, WA 99133

Please fill out the attached packet of paperwork and bring it with you along with your insurance card and co-pay to your above scheduled appointment. This will ensure your appointment runs efficiently.

If you have any questions, please call the Sleep Center at (509) 663-1578 for Wenatchee or (509) 689- 0100 for Brewster.
We look forward to serving you.

Sleep Well. Love Life.

Thank you,

Central Washington Sleep Diagnostic Center Staff

Central Washington Sleep Diagnostic Center, PLLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Full Name ______________________________ SS # ______________
Mailing Address ______________________________ DOB ______________
Physical Address ______________________________ Sex ◻ M ◻ F
City ______________ Zip __________ Phone # ______________
Employer ______________________________ Cell Phone # ______________
Occupation ______________________________ Email ______________
Marital Status ◻ Single ◻ Married ◻ Divorced ◻ Widowed ◻ Separated
Ethnicity(required) ◻ Not Hispanic or Latino ◻ Hispanic or Latino ◻ Unknown
Race(required) ◻ American Indian or Alaska Native ◻ Asian ◻ Black or African American
◻ Native Hawaiian or Other Pacific Islander ◻ White ◻ Other

BILLING INFORMATION

Responsible Party:
Relationship to Patient: ◻ Self ◻ Spouse ◻ Mother ◻ Father ◻ Other __________
Full Name ______________________________ SS # ______________
Mailing Address ______________________________ DOB ______________
City ______________ Zip __________ Sex ◻ M ◻ F
Employer ______________________________ Phone # ______________
Occupation ______________________________ Cell Phone # ______________

Emergency Contact ______________________________ Phone # ______________
How did you hear about us? ◻ doctor ◻ friend ◻ internet ◻ billboard ◻ other __________
Preferred method of contact ◻ phone ◻ email ◻ letter ◻ patient portal ◻ other

INSURANCE INFORMATION

Primary Insurance Company ______________________________
Subscriber Name ______________________________ Date of Birth ______________
ID # ______________________________ Group # ______________

◻ N/A
Secondary Insurance Company ______________________________
Subscriber Name ______________________________ Date of Birth ______________
ID # ______________________________ Group # ______________

ASSIGNMENT AND RELEASE

I hereby authorize Central Washington Sleep Diagnostic Center, PLLC and/or its agents to examine and perform necessary testing to me. I authorize the assignment of insurance benefits, if any, for services rendered to be paid directly to Central Washington Sleep Diagnostic Center, PLLC. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I acknowledge that I have received and read the Notice of Privacy Practices and Patients' Bill of Rights.

I have read and agree to abide by the Patient Financial Policy.

Patient/Guardian Signature ______________________________ Date ______________

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Authorization for Release of Information

Patient Name ____ Date of Birth ___________________________

I. AUTHORIZATION SECTION

Please disclose the following information:

________ The most recent 2 years of pertinent information – chart notes, labs, x-rays, and special tests.

________ All medical records

________ Specific information – Please list ____

The following items must be initialed to be EXCLUDED from use and/or disclosure of other health information:

________ HIV/AIDS ________ Mental health ________ Genetic testing information and/or records

________ Drug/alcohol abuse ________ Reproductive care (minors only) ________ Sexually transmitted diseases

MINORS - a minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted disease (age 14 and older); (2) alcohol and/or drug abuse (age 13 and older); and (3) mental health conditions (age 13 and older)._

Health care information to be released FROM:

Name and/or organization ____

Address ______________________________ City ____________________ State __________ Zip _________

Phone number ____________________________ FAX Number ______________________________

Health care information to be released TO:

Name and/or organization ____

Address ______________________________ City ____________________ State __________ Zip _________

Phone number ____________________________ FAX Number ______________________________

II. EXPIRATION

This authorization ends: Date _________________ or Event ______________________________

III. SIGNATURE

Patient ____ Date ____________________

INCOMPETENT PATIENT - The following individuals may authorize in order of priority: guardian (with valid papers), durable power of attorney for health care decisions, spouse, adult children, parents, adult brothers or sisters.
PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS – I hereby declare under penalty of perjury that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

Parent/Legal Guardian Signature ______________________________________ Date ____________________

Relationship ____

IV. REVOCATION

You may revoke this authorization at any time by signing and dating this section or by writing a letter to Family Health Centers.
Revocation does not affect any actions already taken by Family Health Centers based on this authorization.

I hereby revoke this authorization.

Signature ____ Date ____________________

Review of Systems

(Please check all that apply.)

Patient: ____ Date of Birth: ____________________

Constitutional

- ◻ fatigue, loss of energy
- ◻ night sweats
- ◻ weight loss
- ◻ weight gain
- ◻ waking up early
- ◻ difficulty falling asleep

Eyes

- ◻ blurry vision
- ◻ double vision
- ◻ eye pain
- ◻ redness
- ◻ wears contacts
- ◻ wears glasses

ENT (Ears, Nose, Mouth, Throat)

Ears

- ◻ hearing loss
- ◻ ringing in ears

Nose

- ◻ stuffiness
- ◻ runny nose
- ◻ sneezing
- ◻ post-nasal drip
- ◻ nosebleeds
- ◻ sinus pain/pressure

Mouth/Throat

- ◻ toothache
- ◻ gum pain/bleeding
- ◻ dry mouth
- ◻ sore throat
- ◻ hoarseness
- ◻ trouble swallowing
- ◻ dentures

Neck

- ◻ neck pain
- ◻ neck stiffness
- ◻ lumps
- ◻ swollen glands

Cardiovascular

- ◻ chest pain
- ◻ chest tightness
- ◻ palpitations
- ◻ trouble breathing lying down
- ◻ fainting
- ◻ loss of consciousness
- ◻ heart murmur
- ◻ high blood pressure
- ◻ swelling/edema

Respiratory

- ◻ productive cough
- ◻ nonproductive cough
- ◻ sputum
- ◻ infections
- ◻ coughing up blood
- ◻ shortness of breath
- ◻ wheezing
- ◻ painful breathing
- ◻ exercise intolerance

GI

- ◻ decreased appetite
- ◻ increased appetite
- ◻ heartburn

GU

- ◻ urinary incontinence
- ◻ increased urination at night
- ◻ erectile dysfunction

Musculoskeletal

- ◻ muscle pain
- ◻ muscle weakness
- ◻ back pain

Neurological

- ◻ headache
- ◻ morning headache
- ◻ tingling arms/legs
- ◻ weakness
- ◻ dizziness
- ◻ loss of balance
- ◻ speech disturbance
- ◻ seizures
- ◻ lightheadedness
- ◻ slow thinking
- ◻ slow moving
- ◻ tremor
- ◻ head injury

Psychiatric

- ◻ depression
- ◻ anxiety
- ◻ nervousness
- ◻ stress
- ◻ loss of interest
- ◻ trouble concentrating
- ◻ thoughts of suicide
- ◻ memory loss
- ◻ feelings of guilt
- ◻ paranoia
- ◻ hallucinations
- ◻ decreased work/school performance
- ◻ see people/things others do not see

Endocrine

- ◻ goiter
- ◻ heat/cold intolerance
- ◻ diabetes
- ◻ thyroid problems

Hematologic/Lymphatic

- ◻ anemia
- ◻ transfusions

Allergy/Immunologic

- ◻ seasonal allergies

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PEDIATRIC SLEEP QUESTIONNAIRE

Child's Information	
Child's Name:	Child's Gender: ◻ Male ◻ Female Your provider
Child's Birthdate:	Child's Age:
Parent Name(s):	Today's Date:
Child's Primary Provider:	Child's Referring Provider:

It is important for you to be as accurate and thorough as possible in answering the following questions. The purpose of this questionnaire is to get a complete picture of your child's background and the nature of your child's present problem. This will assist the physician to create an individualized treatment plan.

Child's Problem or Area of Concern
Describe your major concern(s) about your child's sleep?
What treatment has your child received in the past?

Child's Sleep History		
General Sleep Does the child have a regular bedtime routine? ◻ Yes ◻ No Does the child have his / her own bed? ◻ Yes ◻ No Does the child have his / her own bedroom? ◻ Yes ◻ No Is a parent / guardian present when the child falls asleep? ◻ Yes ◻ No		
Child usually falls asleep in: ◻ own room in own bed (alone) ◻ parent's room in own bed ◻ parent's room in parent's bed ◻ sibling's room in own bed ◻ sibling's room in sibling's bed	Child sleeps most of the night in: ◻ own room in own bed (alone) ◻ parent's room in own bed ◻ parent's room in parent's bed ◻ sibling's room in own bed ◻ sibling's room in sibling's bed	Child usually wakes in the am in: ◻ own room in own bed (alone) ◻ parent's room in own bed ◻ parent's room in parent's bed ◻ sibling's room in own bed ◻ sibling's room in sibling's bed
Child is usually put in bed by: ◻ Mother ◻ Father ◻ Both Parents ◻ Sibling ◻ Self ◻ Other		
Write the amount of time the child spends in his / her bedroom before going to sleep: _______ minutes		

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Child's Sleep History (continued)

Child resists going to bed?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
Child has difficulty falling asleep?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
Child awakens during the night?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No
After a night-time awakening, child has difficulty going back to sleep?	□ Yes	□ No	If yes, do you think this is a problem?	□ Yes	□ No

Weekday Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekdays (daytime & nighttime) _____ hours _____ minutes

Child's usual bedtime on weekday nights: _____:______

Child's usual wake time on weekday mornings: _____:______

Weekend Sleep Schedule

Write in the amount of time the child sleeps during a 24 hour period on weekends (daytime & nighttime) _____ hours _____ minutes

Child's usual bedtime on weekend nights: _____:______

Child's usual wake time on weekend mornings: _____:______

Nap Schedule

How many naps does your child take during the day (circle one): 1 2 3 4 5 6 7 8 9 10

What is your child's usual nap time(s): ______:_____ am / pm TO _____:_____ am / pm

______:_____ am / pm TO _____:_____ am / pm

______:_____ am / pm TO _____:_____ am / pm

Child's Daytime Symptoms

Please circle the appropriate number:

1 = Never
2 = less than 1 night / day per week
3 = 1 - 2 nights / days per week
4 = 3 - 5 nights / days per week
5 = 6 - 7 nights / days per week
6 = Unknown

Has trouble getting up in the morning	1	2	3	4	5	6
Falls asleep at school	1	2	3	4	5	6
Naps after school	1	2	3	4	5	6
Has daytime sleepiness	1	2	3	4	5	6
Feels weak or loses muscle control with strong emotions	1	2	3	4	5	6
Reports unable to move when falling asleep or awakening	1	2	3	4	5	6
Sees frightening images when falling asleep or awakening	1	2	3	4	5	6

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Child's Sleep Symptoms

Please circle the appropriate number:

1 = Never
2 = less than 1 night per week
3 = 1 - 2 nights per week
4 = 3 - 5 nights per week
5 = 6 - 7 nights per week
6 = Unknown

Symptom						
Stops breathing during sleep	1	2	3	4	5	6
Has difficulty breathing during sleep	1	2	3	4	5	6
Snores	1	2	3	4	5	6
Restless sleep	1	2	3	4	5	6
Sweating when sleeping	1	2	3	4	5	6
Daytime sleepiness	1	2	3	4	5	6
Poor appetite	1	2	3	4	5	6
Has nightmares	1	2	3	4	5	6
Sleep walks	1	2	3	4	5	6
Sleep talks	1	2	3	4	5	6
Screams in his / her sleep	1	2	3	4	5	6
Kicks legs in sleep	1	2	3	4	5	6
Wakes up during the night	1	2	3	4	5	6
Gets out of bed at night	1	2	3	4	5	6
Trouble staying in his / her own bed	1	2	3	4	5	6
Resists going to bed at bedtime	1	2	3	4	5	6
Grinds his / her teeth	1	2	3	4	5	6
Uncomfortable feeling in legs - creepy-crawly feeling	1	2	3	4	5	6
Wets bed	1	2	3	4	5	6

Child's Past Psychiatric / Psychological History

Condition			
Autism	☐ No	☐ Yes	Age of diagnosis:
Developmental delay	☐ No	☐ Yes	Age of diagnosis:
Hyperactivity / ADHD	☐ No	☐ Yes	Age of diagnosis:
Anxiety / panic attacks	☐ No	☐ Yes	Age of diagnosis:
Obsessive compulsive disorder	☐ No	☐ Yes	Age of diagnosis:
Depression	☐ No	☐ Yes	Age of diagnosis:
Suicide	☐ No	☐ Yes	Age of diagnosis:
Learning disability	☐ No	☐ Yes	Age of diagnosis:
Drug use / abuse	☐ No	☐ Yes	Age of diagnosis:
Behavioral disorder	☐ No	☐ Yes	Age of diagnosis:

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Psychiatric hospital admission	☐ No	☐ Yes	Age of admission:

Child's Past Medical History			
Frequent nasal congestion	☐ No	☐ Yes	Age of diagnosis:
Trouble breathing through nose	☐ No	☐ Yes	Age of diagnosis:
Sinus problems	☐ No	☐ Yes	Age of diagnosis:
Chronic bronchitis or cough	☐ No	☐ Yes	Age of diagnosis:
Allergies	☐ No	☐ Yes	Age of diagnosis:
Allergies to medications	☐ No	☐ Yes	Which one(s):
Asthma	☐ No	☐ Yes	Age of diagnosis:
Frequent colds or flu	☐ No	☐ Yes	Age of diagnosis:
Frequent ear infections	☐ No	☐ Yes	Age of diagnosis:
Frequent strep throat infections	☐ No	☐ Yes	Age of diagnosis:
Difficulty swallowing	☐ No	☐ Yes	Age of diagnosis:
Acid reflux (GERD)	☐ No	☐ Yes	Age of diagnosis:
Poor or delayed growth	☐ No	☐ Yes	Age of diagnosis:
Excessive weight	☐ No	☐ Yes	Age of diagnosis:
Hearing problems	☐ No	☐ Yes	Age of diagnosis:
Speech problems	☐ No	☐ Yes	Age of diagnosis:
Vision problems	☐ No	☐ Yes	Age of diagnosis:
Seizures / epilepsy	☐ No	☐ Yes	Age of diagnosis:
Morning headaches	☐ No	☐ Yes	Age of diagnosis:
Cerebral palsy	☐ No	☐ Yes	Age of diagnosis:
Heart disease	☐ No	☐ Yes	Age of diagnosis:
High blood pressure	☐ No	☐ Yes	Age of diagnosis:
Sickle cell disease	☐ No	☐ Yes	Age of diagnosis:
Genetic disease	☐ No	☐ Yes	Age of diagnosis:
Chromosome problem (ex. Down's)	☐ No	☐ Yes	Age of diagnosis:
Skeleton problem (ex. Dwarfism)	☐ No	☐ Yes	Age of diagnosis:
Craniofacial disorder (ex. Pierre-Robin)	☐ No	☐ Yes	Age of diagnosis:
Thyroid problems	☐ No	☐ Yes	Age of diagnosis:
Eczema (ex. itchy skin)	☐ No	☐ Yes	Age of diagnosis:
Pain	☐ No	☐ Yes	Age of diagnosis:
Head / brain injury	☐ No	☐ Yes	Age of diagnosis:
Meningitis	☐ No	☐ Yes	Age of diagnosis:
Other	☐ No	☐ Yes	Age of diagnosis:

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Child's Current Medications

Please list any medications the child is currently taking:

Medication: Dose: How Often:

____

____

____

____

Child's Long Term Medical Problems

If the child has long-term medical problems, please list the three you think are the most important.

1 ____

2 ____

3 ____

Child's Surgeries / Hospitalizations

Has the child had his / her tonsils removed? ☐ No ☐ Yes Age of surgery: __________

Has the child had his / her adenoids removed? ☐ No ☐ Yes Age of surgery: __________

Has the child ever had ear tubes? ☐ No ☐ Yes Age of surgery: __________

Please list any additional hospitalizations or surgeries:

1 ____ Age: ____________

2 ____ Age: ____________

3 ____ Age: ____________

Child's Health Habits

Does the child drink caffeinated beverages? ☐ No ☐ Yes Amount per day: _________

(ex. Coke, Pepsi, Mountain Dew, Orange Soda, Tea, Coffee, Energy Drinks) Time of last drink: ________

Child's School Performance (if school age)

Child's grade: ____________ Name of school: ______________________________

Has child ever repeated a grade: ☐ No ☐ Yes

Is child enrolled in any special education classes ☐ No ☐ Yes Which one(s): ___________

How many school days has child missed this year? ________

How many school days did child miss last year? __________

How many school days has child been late this year? ______

How many school days was child late last year? __________

Child's grades this year? ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

Child's grades last year? ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Failing

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Child's Family Information

Pregnancy / Delivery

Pregnancy ☐ Normal ☐ Difficult

Delivery ☐ Term ☐ Pre-Term ☐ Post-term

Child's birth weight: ___________

Only child? ☐ Yes ☐ No If no, circle birth order: 1st 2nd 3rd 4th 5th 6th

Mother	Father
Age: ______________	Age: ______________
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Remarried	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Remarried
Education: __________________________________	Education: __________________________________
Work: ☐ Full-time ☐ Part-time ☐ Unemployed	Work: ☐ Full-time ☐ Part-time ☐ Unemployed
Occupation: _________________________________	Occupation: _________________________________

Persons Living in Home

Name: Relationship: Age:

____
____
____
____
____
____

Family Sleep History

Does anyone in the child's family have a sleep disorder? ☐ No ☐ Yes

If yes, mark the disorders and relationship.

Insomnia	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Periodic limb movement d/o	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Sleep walking	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Sleep terrors	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent
Other: ___________________	☐ Mother	☐ Father	☐ Brother / Sister	☐ Grandparent

Is there any other information you think would be helpful for the physician to know?

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NOTICE OF PRIVACY PRACTICES

(Effective 11/1/07)

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

We respect the privacy and confidentiality of your health information. This Notice of Privacy Practices ("Notice") describes how we may use and disclose your medical/health information and how you can get access to this information. This Notice applies to uses and disclosures we may make of all your health information whether created or received by us.

I. OUR RESPONSIBILITIES TO YOU

We are required by law to:

A. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.

B. Comply with the terms of our Notice currently in effect. We reserve the right to change our practices and to make the new provisions effective for all health information we maintain, including both health information we already have and health information we create or receive in the future. Should we make material changes, we will make the revised Notice available to you in the office.

II. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

We may use and disclose your health information for purposes of treatment, payment and health care operations as described below.

A. For Treatment. We may use and disclose your health information to provide you with treatment and services and to coordinate your continuing care. Your health information may be used by doctors, nurses, technologists, students and other health care providers involved in your care to assist them in treating you.

B. For Payment. We may use and disclose your health information so that we can bill and receive payment for the treatment and services you receive. For billing and payment purposes, we may disclose your health information to an insurance company, Medicare, Medicaid or another third party payor.

C. For Health Care Operations. We may use and disclose your health information for our internal operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

III. ADDITIONAL USES AND DISCLOSURES

Under the Privacy Regulations, we may make the following uses and disclosures without obtaining a written Authorization from you:

A. As Required By Law. We may disclose your health information when required by law to do so.

B. Facility Directory. Unless you object, we may use and disclose certain limited information about you in our directory while you are a patient. This information may include your name, your location in CWSDC and your general condition. Our directory does not include specific medical information about you. We may disclose directory information to people who ask for you by name.

C. Persons Involved In Your Care or Payment for Your Care. Unless you object, we may disclose health information about you to a family member, close personal friend or other person you identify who is involved in your care. These disclosure are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

D. Public Health Activities. We may disclose your health information for public health activities.

E. Reporting Victims of Abuse, Neglect or Domestic Violence. If we believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.

F. Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include audits, investigations, inspections and licensure actions.

G. Judicial and Administrative Proceedings. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process.

H. Law Enforcement. We may disclose your health information for certain law enforcement purposes, including, for example, to file reports required by law or to report emergencies or suspicious deaths; to comply with a court order, warrant, or other legal process; to identify or locate a suspect or missing person; or to answer certain requests for information concerning crimes.

I. Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiner, funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.

J. Research in Limited Circumstances. Your health information may be used for research purposes in limited circumstances were research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

K. To Avert a Serious Threat to Health or Safety. When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

L. Military and Veterans. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities.

M. National Security and Intelligence Activities; Protective Services for the Patient and Others. We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

N. Inmates/Law Enforcement Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.
O. Appointment Reminders. We may use or disclose health information to remind you about appointments.
P. Treatment Alternatives and Health-Related Benefits and Services. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.
Q. Business Associates. We may disclose your health information to our business associates under a Business Associate Agreement.

IV. DISCLOSURE REQUIRING YOUR WRITTEN AUTHORIZATION

A. We will obtain your written authorization (an "Authorization") prior to making any use or disclosure other than those described above.
B. A written Authorization is designed to inform you of a specific use or disclosure, other than those set forth above, that we plan to make of your health information. The Authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written Authorization will also specify the name of the person to whom we are disclosing the health information. The Authorization will also contain an expiration date.
C. You may revoke a written Authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes specified in that Authorization except where we have already taken actions in reliance on your Authorization.

V. YOUR INDIVIDUAL RIGHTS

You have the following rights regarding your health information:

A. Right of Access to Personal Health Information. You have the right to inspect and, upon written request, obtain a copy of your health information except under certain limited circumstances.
B. Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by us or by others on our behalf, but does not include disclosures for treatment, payment and health care operations. This request must be made in writing and include a specific date range.
C. Right to Request Restrictions. You have the right to request that we restrict the way we use or disclose your health information for treatment, payment or health care operations. However, we are not required to agree to the restriction. If we do agree to a restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your treatment.
D. Right to Request Confidential Communications. You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number. We will accommodate your reasonable requests.
E. Right to Request Amendment. You have the right to request that we amend your health information. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment if the information: (a) was not created by us; (b) is not part of the health information maintained by us; (c) is information to which you do not have a right of access; or (d) is already accurate and complete, as determined by us. If we deny your request for amendment, we will give you a written denial notice, including the reasons for the denial. In that event, you have the right to submit a written statement disagreeing with the denial. Your letter of disagreement will be attached to your medical record.
F. Right to a Paper Copy of This Notice. If you wish to receive a paper copy of this privacy notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

VI. QUESTIONS AND COMPLAINTS

A. If you believe your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Room 509 F, HHH Building, Washington DC, 20201.
B. To file a complaint with us, you should contact:

Privacy Officer
Central Washington Sleep Diagnostic Center
PO Box 1092
Brewster, WA 98812
(509) 689-6666
nicole@cwsleepcenter.com

C. We will not retaliate against you in any way for filing a complaint against Central Washington Sleep Diagnostic Center.

Central Washington Sleep Diagnostic Center, PLLC

Patients' Bill of Rights

Central Washington Sleep Diagnostic Center, PLLC and staff have adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:

- Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
- Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
- Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Have his or her cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. To assure these preferences are identified and communicated to staff, a discussion of these issues will be included during the initial nursing admission assessment.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
- Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Formulate advance directives regarding his or her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by state laws and regulations).
- Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay in the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his or her medical record within a reasonable time frame (usually within 48 hours of the request).
- Reasonable responses to any reasonable request he/she may make for service.
- Leave the facility even against the advice of his/her physician.
- Reasonable continuity of care.
- Be advised of the facility grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives or if he or she feels the determined discharge date is premature. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.

- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- **All facility personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.**

Patient Responsibilities:

- The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:
- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
- The patient and family are responsible for asking questions about the patient's condition, treatments, procedures, and other diagnostic test results.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient and family are responsible for immediately reporting any concerns or errors they may observe.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her facility care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.