Dedicated Sleep

Dedicated Sleep, LLC
Notice of Privacy Practice
Effective January 1, 2017

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.

Questions? Please contact our Privacy Office at the address/ phone number at the end of this notice.

Who will follow this notice?

We provide health care to patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional that treats you at any of our locations.
- All contracted service partners for sleep and DME services.
- Any healthcare professional authorized to enter information into your chart, including practicing physicians and other credentialed individuals that participate with us in providing care and services.
- Any business associate or partner with whom we share health information.

Our Pledge to You:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in order to provide quality care and to comply with legal requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the current notice.

Changes to this Notice:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. If there is a significant change in our policies, we will change our notice and post the new version in areas of the facilities generally accessible by patients and their families. You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice each time you register for treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you with your consent or with the consent of others who are legally permitted to consent on your behalf for treatment (e.g., sending medical information about you to a specialist as part of a referral); to obtain payment for treatment (e.g., sending billing information to your insurance company or Medicare); and to support health care operations (e.g., comparing patient data to improve treatment methods.)
- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, birth, death, abuse or neglect and domestic reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and other emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, e.g., regarding inmates in their custody, or in response to valid judicial or administrative orders.

- We also may contact you for appointment reminders, or to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you,
- We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of Medical Information

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

- In most cases, you or your personal representative have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we amend the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after your date of service. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- If this notice was sent to you electronically, you have the right to a paper copy of this notice.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
- All written requests or appeals should be submitted to our Privacy Office listed below:

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office at:

Address: Privacy Office C/O Dedicated Sleep 21260 S. Springwater Road, Estacada Oregon 97023

Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.

- Under no circumstance will you be penalized or retaliated against for filing a complaint.

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Acknowledgement of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgement *

I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

Office use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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Informed Patient Consent

Patient Name: _____ DOB: _____

Welcome! We would like to give you a little more information about ourselves, and what to expect during our sleep apnea testing & treatment process. This document contains important information about our professional services and business policies. Please read it carefully, and if you have any questions, we can discuss them together prior to starting the sleep apnea testing and treatment process. When you sign this document, it will represent an agreement between us.

_____

CONFIDENTIALITY AND PRIVACY NOTICE:

Privacy is a very important concern for all those who use our services. In general, the privacy of all communications between a patient and a physician is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

We may need to release basic diagnostic and clinical information to your insurance provider in order to obtain treatment authorization or to get claims paid. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect you or others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency, or if we believe that a patient is threatening serious bodily harm to another. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have together. If you need specific advice, please be aware that formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

I have read and discussed the above agreement. I understand and agree to all of the points discussed above. If at any point I have questions or problems regarding my treatment, I understand how to contact the practice, and receive support for my individual needs. I am providing consent for treatment to include, home sleep testing, diagnostic scans (such as X-ray or Cone Beam CT), and related sleep apnea treatment devices- if sleep disordered breathing is diagnosed.

IN CASE OF EMERGENCY, PLEASE CONTACT DEDICATED SLEEP AT (800) 279-3104

_____ _____

Patient Date

DEDICATED SLEEP™
SLEEP WELL LIVE WELL

21260 S. Springwater Rd | Estacada, OR 97023
Phone: 800-279-3104 | Fax: 949-798-6979 | dentalinfo@dedicatedsleep.net | dedicatedsleep.net

Medical Records Release Form

Patient's Name: _____ **Date of Birth:** _____

By Signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed:

Dedicated Sleep
21260 S. Springwater Rd
Estacada, OR 97023

Patient Signature: _____ **Date signed:**

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Patient Name: Date:

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to assess a person's daytime sleepiness.

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

This refers to your usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you.

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

0 = would never doze or sleep.
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	***Chance of Dozing***
Sitting and Reading?	
Watching TV?	
Sitting inactive in a public place (ex: meeting, theater)?	
Being a passenger in a motor vehicle for an hour or more?	
Lying down to rest in the afternoon if circumstances permit?	
Sitting and talking to someone?	
Sitting quietly after lunch without alcohol?	
In a car, while stopped for a few minutes in traffic?	
TOTAL:	

Thank You!

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COMPREHENSIVE HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your health problem. It is very important to be as accurate as possible in answering the questions. Your partner may be able to assist you.

***Please remember to write your name at the top of each page.**

General Information *(This information will become part of your medical record and will remain confidential.)*

Patient Name:				Date:	
(First)	(Middle)	(Last)			
Address:					
(Street)		(City)		(State)	(Zip)
Home Phone		Work Phone:			
Cell Phone:		May we call you at work?			
Email:		Best way to reach you?			
Date of Birth:		Age:	Sex:	Male	Female
Height:_____	Weight:_____lbs.	Marital Status:	☐ Single	☐ Widowed	
			☐ Divorced	☐ Married/Partner	
SSN:		Occupation:			
Emergency Contact:		Relationship:	Phone Number:		
Referring Physician:		Primary Care Physician:			

Medical History

List current medical conditions for which you are being treated.

Diagnosis	Year	Treating Physician

List all hospitalizations and surgeries you have had. (*Please be thorough and include surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions.)*

Diagnosis	Year	Treating Physician

List medications you are currently taking. (*Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)*

Medication	Reason	Dosage	How often

Please list any allergies we should be aware of:

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Patient Name: DOB: DOS:

DYSFUNCTION				
Can you open your mouth normally?	☐ Completely	☐ Partially		
Do you ever open so wide your mouth locks open?			☐ Yes	☐ No
Do you have any of these sounds in the joint?	☐ Snapping	☐ Grating		
If you have any of these problems is it frequent?			☐ Yes	☐ No
Have you noticed any change in your bite?			☐ Yes	☐ No
MISCELLANEOUS AND ASSOCIATED COMPLAINTS AND QUESTIONS				
Are your jaw muscles ever tired?			☐ Yes	☐ No
Do you have a jaw thrust habit or nervous twitch about the face?			☐ Yes	☐ No
Does your face swell?			☐ Yes	☐ No
Have you ever noticed production of more saliva or less saliva?			☐ Yes	☐ No
Do tears form in your eyes for no apparent reason?			☐ Yes	☐ No
Did the symptoms start after any of the following conditions?			☐ Yes	☐ No
☐ Severe emotional upset	☐ A blow on the jaw	☐ Excessively large bite or yawn		
☐ Traction for cervical whiplash	☐ Traction for cervical arthritis			
How long have you been bothered by this problem?				
Have you had any injury to the jaw or face? If yes, explain.			☐ Yes	☐ No
Have you had any other treatment for this problem? (*If yes, explain-medicine, exercise, dental treatment)*				
Have you had your teeth straightened (*orthodontia)?*			☐ Yes	☐ No
Are you sensitive to metal rings or earrings?			☐ Yes	☐ No
Have you had your bit adjusted by your dentist? (*If yes, please explain when)*			☐ Yes	☐ No
Do you attribute the symptoms to any one incident?			☐ Yes	☐ No
Have you had cortisone injected into the joint? If yes, when?			☐ Yes	☐ No
How many injections?		By whom?		
Do you know if you clench your teeth?			☐ Yes	☐ No
Has anyone mentioned that you grind your teeth (brux) at night during sleep?			☐ Yes	☐ No
Do you chew gum?	Frequently	Moderately	Infrequently	Never
Is there anyone else in your family with a similar problem? (*If yes, explain)*				
Please describe briefly any changes in location or character of symptoms since this problem began				
Please list chronologically names and types of doctors and their locations, whom you have seen in the past for this or related problems. Write on the back of the sheet if necessary				
Did any of the treatments make you feel better? If so, which helped the most? In what manner?				
Did any of the treatments make you feel worse? Which ones? In what manner?				
Please write in any other pertinent information that has not been covered previously.				

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Patient Name: DOB: DOS:

	Yes	No
Do you wake up with sore or aching muscles or joints (including leg or back pain)?	☐	☐
Do you grind or clench your teeth during sleep?	☐	☐
Did you walk or talk in your sleep as a child or adolescent?	☐	☐
Do you now walk or talk in your sleep?	☐	☐
Do you have frightening dreams or nightmares?	☐	☐
Do your dreams or nightmares awaken you?	☐	☐
Do you wet your bed?	☐	☐

Other Sleep Concerns:

Temporomandibular Joint Disorder (TMJ/TMD) & Pain Concerns

Symptom Questions	Right Side	Left Side		Right Side	Left Side
Do your symptoms affect one or both jaw joints?	☐	☐	Pain in forehead	☐	☐
Do you have pain in the jaw joint?	☐	☐	Pain in facial area	☐	☐
Do you have pain in the ear?	☐	☐	Grating sound in joint	☐	☐
Do you have pain around the eyes?	☐	☐	Subjective hearing loss	☐	☐
Pain in lower jaw	☐	☐	Dizziness (vertigo)	☐ Yes	☐ No
Pain in upper jaw	☐	☐	Upset stomach- nausea	☐ Yes	☐ No
Pain in neck	☐	☐	Do you have arthritis?	☐ Yes	☐ No
Pain in shoulder	☐	☐	Have you ever had cervical traction?	☐ Yes	☐ No
Ringing sound in ears (tinnitus)	☐	☐	Fullness, pressure blockage in ear	☐ Yes	☐ No
Headache	☐	☐	Pain in tongue	☐ Yes	☐ No
Total inability to open mouth	☐	☐			

Other Pain Questions

Circle the kind of pain you have:	☐ Sharp	☐ Spreading	☐ Aching	☐ Deep
	☐ Dull	☐ Superficial	☐ Pulsating	☐ Burning
Is the pain?	☐ Constant	☐ Intermittent		
Does the pain last for a moment	☐ Minutes	☐ Hours	☐ All day	
Does the pain start Suddenly?		☐ Gradually		
Does the pain stop suddenly		☐ Gradually		
What time of the day or night is the pain the most severe				
How often do you have pain?				
What is the longest period you have gone without pain?				
What medication(s), if any, do you take to relieve the pain?				
Does rest increase or decrease the pain?				

Please describe any method of positioning the jaw or head that you have found for relieving pain:

Do any of the following normal daily activities cause pain? If yes, indicate where you feel pain.

☐ Yawning	☐ Swallowing	☐ Brushing	☐ Moving shoulders
☐ Chewing	☐ Speaking	☐ Moving head	☐ Moving arms
☐ Singing	☐ Shouting	☐ Moving neck	☐ Moving trunk

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Patient Name: DOB: DOS:

Sleep Questions	Never	Rarely	Often	Frequent	Always
(Females) Does your sleep problem vary according to the stage of your menstrual cycle?	☐	☐	☐	☐	☐
(Females) Have you gone through menopause or had a hysterectomy?	☐	☐	☐	☐	☐
Are you able to fall asleep and awaken on a daily, weekly basis according to your desired schedule?	☐	☐	☐	☐	☐
Do you nap during the day or evening?	☐	☐	☐	☐	☐
Do you feel refreshed after a typical night's sleep?	☐	☐	☐	☐	☐
Do you feel sleepy during the day even when you have slept all night?	☐	☐	☐	☐	☐
Do you feel refreshed after a short nap?	☐	☐	☐	☐	☐
Do you get sleepy while driving?	☐	☐	☐	☐	☐
Have you had an accident or near-accident when driving, due to excessive sleepiness?	☐	☐	☐	☐	☐
Do you fall asleep when you want to stay awake (movies, theater, church, or watching television)?	☐	☐	☐	☐	☐
Are you able to fight off the excessive sleepiness?	☐	☐	☐	☐	☐
Do you have memory or concentration problems?	☐	☐	☐	☐	☐
Do you experience vivid dream-like scenes upon awakening or falling asleep?	☐	☐	☐	☐	☐
When you are angry or laugh, do you ever feel weak, as though you might fall?	☐	☐	☐	☐	☐
Are you ever unable to move or speak upon falling asleep or awakening?	☐	☐	☐	☐	☐
Do you have trouble falling asleep when you go to bed?	☐	☐	☐	☐	☐
When you try to fall asleep does your mind race with thoughts?	☐	☐	☐	☐	☐
When you try to fall asleep do you feel pain?	☐	☐	☐	☐	☐
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	☐	☐	☐	☐	☐
Are you a light sleeper, easily awakened?	☐	☐	☐	☐	☐
Is your sleep disrupted because of your bed partner or others in your household?	☐	☐	☐	☐	☐
Do you snore?	☐	☐	☐	☐	☐
Does your snoring stop for brief periods during sleep?	☐	☐	☐	☐	☐
Does your breathing sometimes stop during sleep?	☐	☐	☐	☐	☐
Is your bed partner disturbed by your snoring?	☐	☐	☐	☐	☐
Do you wake up choking or gasping for breath?	☐	☐	☐	☐	☐
Do you have night sweats?	☐	☐	☐	☐	☐
Do you have heartburn at night?	☐	☐	☐	☐	☐
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	☐	☐	☐	☐	☐
Do you have nasal / sinus congestion at night?	☐	☐	☐	☐	☐
Do you have morning headaches?	☐	☐	☐	☐	☐
Are you a restless sleeper, tossing and turning at night?	☐	☐	☐	☐	☐
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	☐	☐	☐	☐	☐
Do you experience any type of leg or back pain during the night?[18]	☐	☐	☐	☐	☐

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Patient Name: DOB: DOS:

Health Questions *(Please answer the best you can)*		
Are you unable to sleep in a flat position due to shortness of breath?	☐ Yes	☐ No
Do you have a family history of snoring or other sleep disorders?	☐ Yes	☐ No
If yes, please describe:		
Have you ever sustained a brain concussion, head injury or serious blow to the head?	☐ Yes	☐ No
Do you have spells or seizures?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Have you experienced a weight gain in the last year?	☐ Yes	☐ No
If yes, how much weight?		
Has your shirt collar size increase recently?	☐ Yes	☐ No
If yes, by how much?		
Do you smoke?	☐ Yes	☐ No
How many packs per day? How long have you smoked?		
Have you quit smoking?		
How many packs per day prior to quitting? How long did you smoked? Year quit?		
Do you drink alcohol?	☐ Yes	☐ No
If yes, please estimate the number of drinks per day. (beer, wine, or liquor)		
Do you drink caffeinated drinks?	☐ Yes	☐ No
If yes, please estimate the number of drinks per day. (sodas, coffee, or tea)		
(Female) Have you gone through menopause?	☐ Yes	☐ No
(Males) Have you experience any prostate issues? (i.e. Frequent urination)	☐ Yes	☐ No

Sleep Health Concerns & Habits

Describe your sleep problem(s) in your own words.

Describe how and when this problem began.

Describe any treatments you have received for your problem.

Has this been a continuous problem?		☐ Comes and goes	☐ Occasional	☐ Frequent	☐ Constant
How long has your sleep problem bothered you?	☐ Greater than 2yrs.	☐ 1-2 yrs.	☐ Several Months	☐ Last 3 Months	☐ Within the month
What time do you usually go to bed?	Week Days:		Weekends:		
What time do you usually wake up?	Week Days:		Weekends:		
How many hours of sleep do you usually get per night?					
How long does it take you to fall asleep?					
If you awake in the middle of the night, how long are you typically awake for?					
Which shift do you work? (Check all that apply)	☐ Day		☐ Evening		☐ Night

Sleep Questions	Never	Rarely	Often	Frequent	Always
How often do you rotate shifts?	☐	☐	☐	☐	☐
Does your job require overnight travel?	☐	☐	☐	☐	☐
Do you drink alcohol at 6pm?	☐	☐	☐	☐	☐
Do you drink caffeinated beverages after 6pm?	☐	☐	☐	☐	☐
Do you suffer from a loss of libido?	☐	☐	☐	☐	☐
(Males) Have you experienced difficulties with sexual functions?	☐	☐	☐	☐	☐

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AFFIDAVIT FOR INTOLERANCE TO PAP

Check the following that applies:

___I have **NOT** attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and feel it would be intolerable to use for the following reasons (check all that apply below):

___I **HAVE** attempted to use the nasal PAP to manage my sleep related breathing disorder (apnea) and find it intolerable to use on a regular basis for the following reasons (check all that apply below):

Amount of time PAP was used: _____

___ Mask leaks

___ An inability to get the mask to fit properly

___ Discomfort or interrupted sleep caused by the presence of the device

___ Noise from the device disturbing sleep or bed partner's sleep

___ CPAP restricted movements during sleep

___ CPAP does not seem to be effective

___ Pressure on the upper lip causes tooth related problems

___ Latex allergy

___ Claustrophobic associations

___ An unconscious need to remove the PAP apparatus at night

___ Other (Please describe): _____

_____

Based on my intolerance/inability to use PAP, I wish to have the alternative treatment, oral appliance therapy (OAT).

Patient Name:_____

Signature:_____ Date:_____