Patient Name: _____ Medical Record#_____
Last First M.I.

Age: _____ Date of Birth: _____ Sex: M F (circle)

**PHYSICIAN INFORMATION**

**Primary Care Physician**:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

**Referring Physician**:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

Name of Person Referring You to the Sleep Center: _____

Would you like your records to go to any other physician? Yes ☐ No ☐

**Other Physician**:_____ Specialty:_____

Address: _____

Phone: _____ Fax: _____

**1. Briefly describe your sleep problem**: _____

_____

At what age did this problem begin? _____

How does this affect your life and daily activities? _____

_____

How serious a problem is this for you on a scale of 1 to 10? (1 is not serious and 10 is very serious) _____

**2. Have you had any previous evaluations (exam or sleep study)?** ☐ Yes ☐ No

When: _____ Where:_____ Results _____

**3. Have you had any previous treatment?** ☐ Yes ☐ No

When: _____ Where:_____ What type: (i.e., CP AP) _____

4. Please list any medications (prescribed or otherwise) that you have used to help your sleep problem:

| DRUG | AMOUNT | FREQUENCY | HOW LONG? | HOW USEFUL? | PHYSICIAN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**SLEEP HABITS**

**5. If employed, what are your usual working hours?**

Start: _____ a.m./p.m. Stop:_____ a.m./p.m.

**6. Do you ever change work shifts?** ☐ Never ☐ Infrequently ☐ Regularly

**7. Write in the time you usually go to bed and get up on weekdays.**

Go to bed _____ a.m./p.m. Wake Up _____ a.m./p.m.

**8. Write in the time you usually go to bed and get up on weekends.**

Go to bed _____ a.m./p.m. Wake Up _____ a.m./p.m.

**9. Do you have a regular sleep partner?** ☐ Yes ☐ No

**10. On the average, how long does it take you to fall asleep?** _____Minutes

**11. What do you ordinarily do just prior to going to sleep?** (e.g. reading, TV, bath, etc.)

☐ Reading ☐ TV ☐ Bath ☐ Exercise ☐ Eat

Other: _____

**12. On the average, how often do you wake up during the night?** _____ Times

**13. Do you ever wake up too early in the morning and then are unable to return to sleep?** ☐ Yes ☐ No

**14. On the average, how long are you actually asleep at night?** _____hours _____minutes

**15. How do you ordinarily awaken?** ☐ Spontaneously ☐ Alarm Clock ☐ Other

**16. How difficult is it for you to awaken and get out of bed after sleeping?**

☐ Very Difficult ☐ Difficult ☐ Sometimes Difficult ☐ No Problem

**17. How long does it take for you to be alert and functioning after sleeping?** _____ hours _____ minutes

**18. Do you nap or return to bed after arising?**

If yes, how many times per day? _____Average length of nap:_____ _____ hours _____ minutes

**19. Are you bothered by sleepiness during the day?** ☐ Yes ☐ No

**20. Do you feel you get too much sleep at night?** ☐ Yes ☐ No

**21. Do you feel you get too little sleep at night?** ☐ Yes ☐ No

**22. Do you usually feel tired during the day?** ☐ Yes ☐ No

If yes, what do you attribute this to? _____

_____

**23. Do you find yourself falling asleep when you don't mean to?** ☐ Yes ☐ No

If yes, describe: _____

_____

How long does the sleep episode last? _____ hours _____minutes

Do you feel rested or refreshed after the sleep episode? ☐ Yes ☐ No

**24. Have you ever suddenly fallen?** ☐ Yes ☐ No

**25. Have you ever experienced sudden bodily weakness (jaw, head, shoulders, arms, legs)?** ☐ Yes ☐ No

If you have suddenly fallen or experienced weakness, were you aware of things around you? ☐ Yes ☐ No

Was the fall or weakness brought on by any particular event or feeling (laughter, fear, sadness, etc)? ☐ Yes ☐ No

If so briefly describe: _____

_____

**26. Have you ever-experienced muscle weakness or paralysis upon:**

Going to sleep? ☐ Yes ☐ No

Awakening from sleep? ☐ Yes ☐ No

How often does this occur? _____ Times/Week

**27. Have you experienced seeing things or hearing voices that weren't real?**

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

**28. Have you experienced a feeling like falling or the bed moving?**

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

**29. Do you have difficulty breathing at night?**

If so briefly describe: _____

_____

_____

How often? _____ Times/Night When did this first occur? _____ (Age)

**30. Have you been told you snore when you sleep?** ☐ Yes ☐ No

Does the snoring disturb: ☐ Yes ☐ No

A bed partner (or someone in the same bedroom)? ☐ Yes ☐ No

Someone in the next room? ☐ Yes ☐ No

**31. Have you been told you stop breathing when you sleep?** ☐ Yes ☐ No

**32. Have you experienced, upon laying in bed, before sleep, or on awakening from sleep, a restless of legs, "nervous leg," a creeping crawling sensation of legs or twitching?** ☐ Yes ☐ No

How often does this occur? _____ times/week

How long does the sensation last? _____ minutes

Does anything relieve the sensation (e.g. getting out of bed, a massage, medication, etc)? _____

_____

When did you first experience this? _____ (age) ☐ Yes ☐ No

**33. Has anyone ever told you that your arms or legs jerk or twitch while you are asleep?** ☐ Yes ☐ No

If yes, how often during the night does this occur? _____ times/night

How many nights per week does this happen? _____ times/week

At week age did this come to your attention? _____

**Does this seem to awaken you from sleep?** ☐ Yes ☐ No

**34. Have you ever experienced doing something without being aware at the time of this action?** ☐ Yes ☐ No

If so briefly describe: _____

_____

_____

How often does this occur? _____ times/week

**35. Do you know or do others tell you that:** Treatment

Talk while apparently asleep? ☐ Yes ☐ No _____ times/week _____ age started _____

Walk while apparently asleep? ☐ Yes ☐ No _____ times/week _____ age started _____

Grit teeth while apparently asleep? ☐ Yes ☐ No _____ times/week _____ age started _____

Wet the bed during sleep? ☐ Yes ☐ No _____ times/week _____ age started _____

Wake up screaming or seemingly afraid? ☐ Yes ☐ No _____ times/week _____ age started _____

Have disturbing dreams? ☐ Yes ☐ No _____ times/week _____ age started _____

Have unusual movements? ☐ Yes ☐ No _____ times/week _____ age started _____

Awake during the night with headaches? ☐ Yes ☐ No _____ times/week _____ age started _____

Have erections while asleep (males)? ☐ Yes ☐ No _____ times/week _____ age started _____

**ALLERGIES** *(Specify drug and reaction):*

_____ _____

_____ _____

_____ _____

_____ _____

**MEDICATIONS**

Do you use any prescribed medications either regularly or occasionally? ☐ Yes ☐ No

If so, please list by name below (include over the counter medications, herbal products, supplements, and vitamins)

| Name of Medication | Amount | How Often | Reason Used | How Long Used | Prescribing Physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
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| | | | | | |

Give the year of your last physical examination: _____

Results of this exam: _____

Height: _____ inches Weight: _____ pounds Neck size: _____ inches

**Have you now or ever in the past experienced any health problems or had surgery associated with the below listed areas?**

| | Yes | Type of Problem | Dates | Physician, Clinic or Hospital |
|---|---|---|---|---|
| A - mental health | | | | |
| B – head or nervous system | | | | |
| C – eyes, ears, nose, mouth, throat | | | | |
| D – heart, circulation | | | | |
| E – breathing (lungs) | | | | |
| F – stomach, digestive | | | | |
| G – urine, kidney | | | | |
| H – sexual | | | | |
| I – bones, joints, arms, legs | | | | |
| J – diabetes, glands | | | | |
| K – blood pressure | | | | |
| L – weight problems | | | | |
| M - other | | | | |

**SOCIAL HISTORY** (tobacco, caffeine, alcohol, drug use)

Do you currently smoke cigarettes? ☐ Yes ☐ No How many years? _____ # packs per day _____

Have you used tobacco products like cigars, pipes, or smokeless tobacco? ☐ Yes ☐ No

How many years? _____ # per day _____

Do you currently consume alcohol? ☐ Yes ☐ No

How many years? _____ What type? _____ Amount per day _____

On the average, how many alcoholic beverages do you drink on weekdays? _____

On the average, how many alcoholic beverages do you drink on the weekends? _____

Have you received treatment for substance abuse? ☐ Yes ☐ No

On average, how much do you drink of the following beverages?

Coffee _____ cups/day

Tea _____ cups/day

Carbonated or other soft drinks _____ cups/day

**OCCUPATIONAL HISTORY**

Current job _____ Year started _____

Previous positions _____

**FAMILY HISTORY**

Marital Status: _____ Number of Children _____ Ages _____

| Family member | Age | Living | Deceased | Illnesses* | Cause of Death | List Sleep Problems |
|---|---|---|---|---|---|---|
| Father | | | | | | |
| Mother | | | | | | |
| Brothers | | | | | | |
| | | | | | | |
| | | | | | | |
| Sisters | | | | | | |
| | | | | | | |
| | | | | | | |
| Children (indicate sex) | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.*

# EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column and enter the total in the last box.

| Situation | Responses | Score |
|---|---|---|
| **Sitting and Reading** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Watching Television** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting inactive in a public place, for example, a theater or a meeting** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **As a passenger in a car for an hour without a break** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Lying down to rest in the afternoon** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting and talking to someone** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **Sitting quietly after lunch when you've had no alcohol** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **In a car while stopped in traffic** | 0 = would never doze<br>1 = slight chance of dozing<br>2 = moderate chance of dozing<br>3 = high chance of dozing | |
| **TOTAL SCORE** | | |

**REVIEW OF SYSTEMS** Check all that apply

| **General** | **Yes** | **No** |
|---|---|---|
| Weight gain/loss | ☐ | ☐ |
| Difficulty falling asleep | ☐ | ☐ |
| Need to cut down alcohol consumption | ☐ | ☐ |
| Fever | ☐ | ☐ |
| Change in appetite | ☐ | ☐ |

| **Skin** | **Yes** | **No** |
|---|---|---|
| Rash, sore, or excessive bruising | ☐ | ☐ |
| Lump or growth on skin | ☐ | ☐ |

| **Eyes** | **Yes** | **No** |
|---|---|---|
| Wear glasses | ☐ | ☐ |
| Decreased vision | ☐ | ☐ |
| Pain in eyes | ☐ | ☐ |

| **Ears, Nose, Throat, Mouth** | **Yes** | **No** |
|---|---|---|
| Difficulty or changes in hearing | ☐ | ☐ |
| Earaches | ☐ | ☐ |
| Discharge from ears | ☐ | ☐ |
| Buzzing or ringing in ears | ☐ | ☐ |
| Frequent sneezing | ☐ | ☐ |
| Nose stuffiness or running | ☐ | ☐ |
| Recurrent sore throat | ☐ | ☐ |
| Persistent hoarseness | ☐ | ☐ |
| Dental problems | ☐ | ☐ |
| Sinus problems | ☐ | ☐ |
| Lymph glands or nodes | ☐ | ☐ |
| Frequent nose bleeds | ☐ | ☐ |

| **Genitourinary** | **Yes** | **No** |
|---|---|---|
| Painful urination | ☐ | ☐ |
| Frequent urination | ☐ | ☐ |
| Blood in urine | ☐ | ☐ |
| Difficulty emptying bladder | ☐ | ☐ |

| **Musculoskeletal** | **Yes** | **No** |
|---|---|---|
| Painful joints | ☐ | ☐ |
| Sore muscles | ☐ | ☐ |
| Back pain | ☐ | ☐ |
| Pain in calves of legs | ☐ | ☐ |
| Weakness in extremities | ☐ | ☐ |
| Numbness in extremities | ☐ | ☐ |

| **Neuropsychiatric** | **Yes** | **No** |
|---|---|---|
| Anxiety | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Frequent or severe headaches | ☐ | ☐ |
| Dizziness or faintness | ☐ | ☐ |
| More nervous than average person | ☐ | ☐ |

| **Cardiovascular** | **Yes** | **No** |
|---|---|---|
| Chest pain | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ |
| Abnormal swelling in legs/feet | ☐ | ☐ |
| Fatigue or tire easily | ☐ | ☐ |

| **Respiratory** | **Yes** | **No** |
|---|---|---|
| Cough | ☐ | ☐ |
| Blood in sputum | ☐ | ☐ |
| Wheezing | ☐ | ☐ |

| **Endocrine** | **Yes** | **No** |
|---|---|---|
| Excessive thirst or urination | ☐ | ☐ |
| Change in sexual drive/performance | ☐ | ☐ |
| Change in heat or cold tolerance | ☐ | ☐ |

| **Gastrointestinal** | **Yes** | **No** |
|---|---|---|
| Frequent heartburn/indigestion | ☐ | ☐ |
| Nauseas or vomiting | ☐ | ☐ |
| Diarrhea | ☐ | ☐ |
| Constipation | ☐ | ☐ |
| Blood in stools | ☐ | ☐ |
| Ulcers | ☐ | ☐ |

| **For Women Only** | **Yes** | **No** |
|---|---|---|
| Irregular periods | ☐ | ☐ |
| Bleeding between periods | ☐ | ☐ |
| Are you pregnant | ☐ | ☐ |
| Date of last menstrual period | ☐ | ☐ |
| Ever have an abnormal Pap smear | ☐ | ☐ |
| Lump or growth on breast | ☐ | ☐ |

| **Allergic/Immunologic** | **Yes** | **No** |
|---|---|---|
| Hay fever | ☐ | ☐ |
| Hives | ☐ | ☐ |
| Immunodeficiency | ☐ | ☐ |

| **Hematologic/Lymphatic** | **Yes** | **No** |
|---|---|---|
| Anemia | ☐ | ☐ |
| Excessive bleeding or bruising | ☐ | ☐ |
| Blood transfusions | ☐ | ☐ |

**Reviewed by:**

_____ M.D. _____Date

_____ M.D. _____Date

# HOSPITAL ANXIETY AND DEPRESSION SCALE

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the last week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A. I feel tense or "wound up"
3 All of the time
2 A lot of the time
1 From time to time
0 Not at all

D. I still enjoy things I used to enjoy
0 Definitely as much
1 Not quite so much
2 Only a little
3 Hardly at all

A. I get a sort of frightened feeling as if something awful is about to happen
3 Very definitely and quite badly
2 Yes, but not too badly
1 A little, but it doesn't worry me
0 Not at all

D. I can laugh and see the funny side of things as much as I always could
1 Yes
2 Not quite so much now
3 Definitely not so much now
4 Not all

A. Worrying thoughts go through my mind
3 A great deal of the time
2 A lot of time
1 From time to time, but not too often
0 Only occasionally

D. I feel cheerful
3 Not at all
2 Not often
1 Sometimes
0 Most of time

A. I can sit at ease and feel relaxed
0 Definitely
1 Usually
2 Not often
3 Not at all

D. I feel as if I am slowed-down
3 Nearly all of the time
2 Very often
1 Sometimes
0 Not at all

A. I get sort of frightened feeling, like "butterflies in the stomach"
0 Not at all
1 Occasionally
2 Quite often
3 Very often

D. I have lost interest in my appearance
3 Definitely
2 I don't take as much are as I should
1 I may not take as much care
0 I take just as much case as ever

A. I feel restless, as though I have to be on the move
3 Very much indeed
2 Quite a lot
1 Not very much
0 Not at all

D. I look forward with enjoyment to things
0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

A. I get sudden feelings of panic
3 Very often indeed
2 Quite often
1 Not very often
0 Not at all

D. I can enjoy a good book, radio or TV program
0 Often
1 Sometimes
2 Not often
3 Very seldom

A total: _____ D total: _____

Name: _____ Date: _____

# TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE / SLEEP

*SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.*

| Today's Date | Day of the week | Type of Day Work, School, Off, Vacation | Noon | 1PM | 2 | 3 | 4 | 5 | 6PM | 7 | 8 | 9 | 10 | 11PM | Midnight | 1AM | 2 | 3 | 4 | 5 | 6AM | 7 | 8 | 9 | 10 | 11AM |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| sample | Mon. | Work | | E | | | | | A | | | | I | | | | | | | | | C M | | | | |
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week 1

week 2

Tampa Pulmonary and Sleep Specialists
4620 N. HABANA AVE., SUITE 101. TAMPA, FL 33614
TELEPHONE (813) 875-9362 FAX (813) 876-7055

# PATIENT REGISTRATION FORM

IS TODAY'S VISIT RELATED TO ACCIDENT OR INJURY ? (YES OR NO) _____

IF YES, AUTO OR WORK? _____ DATE OF ACCIDENT/INJURY: _____

RACE: _____ ETHNICITY: _____ DOB: _____ SS#: _____

NAME: _____
FIRST MIDDLE LAST SUFFIX

ADDRESS: _____
STREET CITY STATE ZIP CODE

EMAIL: _____

TELEPHONE #: ( ) _____ ( ) _____ ( ) _____
HOME WORK CELL

EMPLOYER: _____ ADDRESS: _____

REFERRING PHYSICIAN: _____
NAME: ADDRESS:

## INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____ GROUP #: _____

CLAIM ADDRESS: _____

TELEPHONE #: ( ) _____ MEMBER ID #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS #: _____

PATIENT'S RELATIONSHIP TO INSURED: _____ SUBSCRIBER'S DATE OF BIRTH: _____

## SECONDARY INSURANCE COMPANY: _____ GROUP #: _____

CLAIMS ADDRESS: _____

TELEPHONE #: ( ) _____ MEMBER ID #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS #: _____

PATIENT'S RELATIONSHIP TO INSURED: _____ SUBSCRIBER'S DATE OF BIRTH: _____

## RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY IF OTHER THAN PATIENT: _____
LAST FIRST M.I.

SS #: _____ DOB: _____

ADDRESS: _____

TELEPHONE #: _____ EMPLOYER: _____

**Tampa Pulmonary and Sleep Specialists**
**4620 N. HABANA AVE., SUITE 101. TAMPA, FL 33614**
**TELEPHONE (813) 875-9362 FAX (813) 876-7055**

## ASSIGNMENT OF BENEFITS FORM

**Name of Insured (print):** _____

**Social Security Number:** _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made of on my behalf to Tampa Pulmonary and Sleep Specialists, for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on filed by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowlegement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print):

_____

Relationship to Insured:

_____

Signature of Insured or Parent/Guardian:

_____

Date:

_____

# HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

**TAMPA PULMONARY AND SLEEP SPECIALISTS**

**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.**

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

**I. Your Rights.**
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 813-875-9362.

**II**. **We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each**:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

**III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization**. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court

order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

**IV**. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

• Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

• Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

• Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

**V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:**

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

1) BAYCARE
2) LABCORP

**VI. Our Duties.**
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

**VII. Complaints to our Practice and the Government.**
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

**VIII. Contact Information.**
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer Elvira Kirksey at 813-875-9362.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775

# HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent *if other than your home*. (Confidential Communications).

   _____

   _____

4. Please indicate if you want all correspondance from our office sent in a sealed envelope marked "**CONFIDENTIAL**": Yes: ☐ No: ☐

5. Please print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other than your home phone number*: (  ) _____ Email Address: _____@_____

6. Can contidential messages ( e., appointment reminders) be left on your telephone answering machine or voicemail? Yes: ☐ No: ☐

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

| | |
|---|---|
| Tampa Pulmonary and Sleep Specialists | 4620 N. Habana Ave., Suite 101, Tampa, FL |

Tampa Pulmonary and Sleep Specialists
4620 North Habana Avenue, Suite 101
Tampa, Florida 33614

# ACKNOWLEDGEMENT OF RECEIPT OF NOTE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowlegement"

I,_____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

**For Office Use Only:**
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice but acknowledgement could not be obtained because:

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

_____

_____

_____