SLEEP HEALTH
CLINIC

Phone: (360) 602.1218
Fax: (360) 991.0291
2501 NE 134TH ST, STE 203
VANCOUVER, WA 98686

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last name: _____ First Name: _____

Middle Initial: _____

Date of Birth: _____ Gender: _____

Social Security Number: _____

Address: _____ City: _____

State: _____

Zip code: _____ Cell phone: _____

Home phone: _____□ same as cell phone

Email: _____

Current occupation: _____

Ethnicity: _____

Language: _____

Emergency contact Name: _____ Phone: _____

Relationship: _____

Primary Care Physician: _____ Office name/clinic: _____

Pharmacy Name: _____ Phone number: _____
Address: _____ City: _____State: _____

Zip code: _____

INSURANCE INFORMATION: (Please include a copy front and back)

Primary Insurance: _____Primary Insured Name: _____

Date of Birth: _____ ID number: _____Group number: _____
Relationship to patent: □ self □ spouse □ other

Secondary Insurance: _____Insured Name: _____

Date of Birth: _____ ID number: _____Group number: _____

Relationship to patient: □ self □ spouse □ other Insurance

Address: _____ City: _____State: _____

Zip code: _____

PREFERRED CONTACT □ email □ phone □ SMS/text message (carrier charge may apply)

Please be informed we may send information regarding your office/telemedicine appointment/ appointment reminder/prescription/refills via your preferred contact method of delivery.

CONSENT TO TREATMENT

As a patient, you have the right to be informed of your medical condition, recommended diagnostic procedures and treatment options. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test/treatment ordered for you. If you have any concerns regarding any test or treatment recommend by your physician, we encourage you to ask questions.

I hereby voluntarily consent to the provision of care, diagnosis and/or treatment by Sleep Health Clinic and I hereby acknowledge that such consent will remain in effect until it is revoked in writing.

TELEMEDICINE CONSENT

I understand that a treating physician may use telemedicine technologies to deliver health care services to a patient when they are located at a different site than the physician's office. I, hereby consent to Sleep Health Clinic providing health care services to me via telemedicine. I understand that all laws related to patient privacy, protected health information apply to telemedicine. In case a telemedicine visit is not available, a face-to-face visit with the physician may be recommended. I understand that I will be responsible for any copayment or coinsurance or any balance amount that is not paid by the insurance that apply to my telemedicine visit. I may revoke my consent in writing at any time by contacting Sleep Health Clinic. As long as this consent has not been revoked Sleep Health Clinic may provide health care services to me via telemedicine without the need for me to sign another consent form.

MEDICATION REFILLS

If a refill is requested prior to scheduled office visit, refill requests will be typically handled within 24 hours, unless there is a problem and we will notify you otherwise. Please do not wait until you are out of medication before calling your pharmacy for a refill. Refill requests must be made during office hours to avoid delays. Refill requests may not be authorized at night or during the weekends.

NOTICE OF PATIENT PRIVACY

At Sleep Health Clinic, we are sincerely committed to patient privacy. This policy is available on the website at www.SleepHealth.clinic as well.

Under the Health Insurance Portability and accountability (HIPAA)laws, any " individually identifiable health information" including patient name, date of birth, SSN, telephone number, email address, demographic details, biometric identifiers, medical record number, car registration number, credit card details or payment information, past/present/future medical history, treatment history, patient data in any written/image/video format that contains identifiable information are protected.

Permitted use and disclosure of Protected Health Information (PHI)
Your personal and demographic information, medical and medication history and insurance details would be obtained from you and verified at every appointment to ensure the information we have on file is accurate and updated. We may use your PHI for the following:
1. Treatment - to provide and coordinate your health care and related services; for example, we may disclose your health information to your referring physician, primary care physician or any other physician/provider who is involved in your health care.
2. Payment - insurance payors may require copies of your medical information to determine coverage /benefits of health care services, to pay or reimburse your health care physician for the services rendered. Billing companies also use the PHI to process the claims before submitting to your insurance. Please be informed that the insurance payors, billing companies are also regulated by the HIPAA laws.
3. Health care operations - licensing, credentialing and accreditation, quality assessment activities, medical reviews or audits, legal services, clinic management and general administration.
This clinic has no jurisdiction over any entity that is mandated by law to use PHI as regulated by the US Department of Human and Health Services (HHS). For further details, please refer to the following link.
https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Our clinic will not use your PHI for marketing purposes without your permission.
Your PHI would not be disclosed to your family members or friends without your verbal or written permission.
In case of termination of care at this clinic, your health information would continue to be protected as outlined in this notice.
Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. We will no longer use or disclose your PHI for the reasons described in the authorization.

If you have any concerns regarding our privacy practices, please contact us at 360-602-1218. Any complaints submitted to the clinic must be submitted in writing. You will not be penalized for filing a complaint. This practice reserves the right to amend our privacy policy as dictated by law, which will be posted on our website.
You are entitled to receive a paper copy of this notice of privacy practices at any time.

I acknowledge that this clinic's Notice of Privacy Practice has been made available to me.

RELEASE OF PHI TO FAMILY:

I hereby authorize the physician and the medical staff at the Sleep Health Clinic to discuss my protected health information with the following person(s):

Name/Phone number:_____Relationship:_____ Name/ Phone number:_____ Relationship:_____

□ I decline. Please do not discuss my care with family members.

FINANCIAL AND OTHER CLINIC POLICIES

Please note the amount of deductible or coinsurance or copay is determined by your insurance plan and not by your physician. It is, therefore, important that you understand/ verify your insurance plan benefits, limitations, requirement for prior authorization or referrals and coverage provisions.

Credit card on file
Sleep Health Clinic believes in making our billing process as simple as possible. We accept credit card, cash, checks. Patients may be required to keep their credit card on file with our office. Your card will be scanned with a card reader (with end to end encryption technology) and the card number stored only in your payment gateway securely. Credit cards on file will be used only when there is a copay for office visits or any account balance after your insurance processes your claim. Please make sure your bills are paid within 14 business days.
If your credit card payment is declined, we will contact you.

Your account may become delinquent if not paid within 30 days after the date of the original statement. Unpaid balances after 90 days from the date of the original electronic bill/statement may be subjected to debt collections.

Please provide us with your updated primary, secondary insurance information at the time of scheduling your appointment/before or during your office visit/telemedicine visit. Any amount that is not paid by the insurance is patient responsibility.

Please let us know if you choose to pay directly, in which case, we will not submit a claim to the insurance company.

No show/late cancellation fee
If you want to cancel your appointment, please notify us at least 24 hours before your appointment to avoid a late cancellation fee of $25.
Please notify us at least 48 hours (during business hours) prior to your scheduled Sleep Study or there will be a $100.00 cancellation fee.

Miscellaneous
For phone calls or paper work requiring more than 10 minutes, you may be charged $25.

I acknowledge that this clinic's patient financial responsibility policy has been made available to me.

Patient/Responsibility party signature: _____ Date: _____