GHALY
sleep center

6713 Collamer Road
East Syracuse, NY 13057
Phone: 315-463-0421
Fax: 315-463-0466

Thank you for scheduling a new patient consult at The Ghaly Sleep Center.

You are scheduled for _____ at _____.

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME SO YOU CAN BE CHECKED IN AND READY FOR THE PROVIDER.

Please bring photo ID, insurance card, and COMPLETED paperwork to your appointment. Copays will be collected AT THE TIME OF SERVICE. If you are responsible for a copay and are unable to pay at the time of service, you will be asked to reschedule your appointment. Please note that **if you arrive AFTER your scheduled appointment time, you may be asked to reschedule**. If you need to cancel or reschedule your appointment, please give 24 hours notice.

If you have any questions or concerns, please contact our office at (315) 463-0421.
Thank you,
The Ghaly Sleep Center

We are conveniently located right off Route 481, in the same building as Alexander & Associates.

From the East: Take Route 298 West towards Fly Road; we are the 2nd building on the right after the 481 on-ramp.

From the North: Take Route 481 South to Exit 7, then take a right onto Route 298; we are the 2nd building on the right.

From the South: Take Route 481 North to Exit 7, then take a right onto Route 298; we are the 2nd building on the right.

From the West: Take Route 298 East past Fly Rd; we are on the left just past Dunkin Donuts.

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SLEEP LAB REGISTRATION

Please completely fill out the information below.

Last Name:_____First Name:_____Date:_____

Address:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone: _____

SS#:_____DOB:_____Age: _____ Sex: Male □ Female □

Height:____ft._____in. Weight:_____lbs. Current Working Status: Working □ Retired □ Disabled □

Email Address: _____ Check to enroll in Patient Portal □

Circle one: Single Married Divorced Widowed Separated Emergency

Contact:_____Contact Phone: _____

Referring Physician:_____Phone: _____

Address: _____

Medical Insurance: Insurance Carrier: _____ Policy Holder:_____

_____Relationship:_____

SS#:_____DOB:_____Policy Holder's Employer: _____

Policy ID#:_____Group #:_____

Medications: _____

Past Medical History/ Surgeries: _____

Allergies: _____

Do you Smoke: Yes ___ No ___ Former ____ - If yes, when did you quit _____

Did you receive the flu vaccine: Yes __ No _____ - If yes, approx. when _____
Did you receive the COVID vaccine: Yes __ No _____ - If yes, approx. when and which one _____
Did you receive the Pneumonia vaccine (60 and older): Yes __ No _____ - If yes, approx. when _____
Do you have any advance directives? (i.e. health care proxy): Yes ____ No _____
Do you have a medical power of attorney?: Yes_____ No _____

• *6713 Collamer Road, East Syracuse, NY 13057* •

P: (315) 463-0421 *F: (315) 463-0466* *www.ghalysleepcenter.com*

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EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze off or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would affect you.

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

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you circle a number (0-3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place- for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
	Total Score:

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HIPAA PATIENT CONSENT FORM

New York State law prohibits our medical office staff from speaking with any individual other than you regarding any of your medical health information. This includes information regarding your condition, medication, appointments, or test results. Patients have the right to privacy and confidential records. You have the right to give consent so that protected health care information (PHI) may be disclosed so that our office can carry out your treatment, obtain payment, and conduct healthcare operations (TPO). **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** Notice of Privacy Practices & Policy provides a more complete description of the law and health information disclosures. Patients have the right to view this notice and copies are available in our office.

Ghaly Sleep Center / Sleep Insights Medical Associates PLLC needs your consent to be able to call your home with messages regarding health information and appointments. We will also need your consent to allow us to discuss your health information with anyone else. Your consent will be noted as you complete the form below.

_____ _____

Print Patient Name (and Guardian name if applicable) **Patient Date of Birth**

I give my consent for **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** to use and disclose my PHI to carry out TPO. With this consent **Ghaly Sleep Center / Sleep Insights Medical Associates PLLC** may mail items or call my home (or other alternate locations) to facilitate treatment, payment, and healthcare operations. They may leave messages concerning healthcare information (such as appointment reminders, payment questions and clinical care) on voicemail, message machines, and with individuals who answer my phones.

____ I do not wish to designate anyone on my behalf with whom to discuss my PHI.

I give my consent to Ghaly Sleep Center / Sleep Insights Medical Associates PLLC to also specifically speak with:

____ spouse: _____

____ relative: _____

____ DOT or employer-directed physician: _____

____ other: _____

Ghaly Sleep Center / Sleep Insights Medical Associates PLLC may speak with the above-named individuals regarding any of my health information, including, but not limited to clinical information, physician advice and treatment, appointments, and payment information without limitation except for the following:

_____

_____

I HAVE READ AND UNDERSTOOD ALL OF THE ABOVE INFORMATION.

_____ _____

Signature of Patient **Date**

AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION THROUGH A HEALTH INFORMATION EXCHANGE ORGANIZATION

A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information regarding my care and treatment held by other participating providers to provide me with better care. I authorize Ghaly Sleep Center / Sleep Insights Medical Associates PLLC to access any of my health information that is available in an HIE, including health information exchange organizations HealtheConnections, Surescripts, amongst other third party health information exchange organizations, and Ghaly Sleep Center / Sleep Insights Medical Associates PLLC will also make my Ghaly Sleep Center / Sleep Insights Medical Associates PLLC health information available through HIEs in which it participates unless I opt out.

The third party health information exchange organizations share health information electronically and meet the privacy and security standards of HIPAA and New York State Law. The choice I make in this form will not affect my ability to get medical care. I also have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

If I opt out, by checking the box below, Ghaly Sleep Center / Sleep Insights Medical Associates PLLC will exclude all of my Ghaly Sleep Center / Sleep Insights Medical Associates PLLC health information from the HIEs in which Ghaly Sleep Center / Sleep Insights Medical Associates PLLC participates.

[ ] I hereby opt out of providing access to any health information available in a health information exchange.

_____ _____

Signature of Patient **Date**

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

PATIENT RESPONSIBILITY AGREEMENT

The doctors and staff of Ghaly Sleep Center / Sleep Insights Medical Associates PLLC appreciate the confidence you have shown in choosing us to provide for your medical care. We are committed to providing you with the highest quality healthcare. Please read and sign this form to acknowledge your understanding of our patient financial policies.

PATIENT FINANCIAL RESPONSIBILITIES

The patient (or patient's guardian, if a minor) is responsible for payment for his/her treatment and care.

- Patients are responsible for the payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Payment is due at the time of service. We accept cash, checks, debit cards, Visa, MasterCard, American Express and Discover.
- ***ONLY patients with high deductible commercial plans who: 1.) do not have secondary insurance or Medicaid and 2.) have not met their deductible must pay the following at time of service:***
  - $150 is due at time of service for all consultations.
  - $50 is due at time of service for all follow-up appointments.
  - $100 at the time of scheduling for all sleep studies.

  Any overpayments will be applied to future dates of services or refunded in full.
- Patients may incur and are responsible for the payment of the following additional charges:
  - A $40 fee for all returned checks.
  - A $50 fee will be applied towards all no-show office visits and $100 fee for all no-show sleep studies.
    While we understand there may be times when you miss an appointment due to emergencies or obligations, Sleep Insights requires a 24-hour notice for all cancelled appointments.
- Patients may be discharged from the practice if two (2) or more appointments are no showed.

INSURANCE

The following are the patient's responsibility:

- Patients must bring their insurance card to each visit.
- Notify our office of any changes to insurance/address/phone numbers.
- If there is a change in insurance and we are not notified prior to the change or we do not accept the new insurance, patient may be responsible for payment in full.
- Know copays, benefits and coverage and determine if doctor(s) are in-network providers prior to first visit.
- Pay for any allowed amounts not covered by insurance.

If you do not have insurance benefits, please contact the Billing Department to set up payment arrangements.

PATIENT AND EMPLOYEE SAFETY

We must assure a safe work environment for our employees. Sexual advances and/or physical assault of any kind upon any of our staff members will result in immediate discharge from our clinic. Discharge in these cases will be at the sole discretion of the treating provider.

CELL PHONE USE CONSENT

Sleep Insights Medical Associates PLLC may contact the patient's cell phone regarding appointments, test results, billing inquiries and any other matter associate with the patient's account. Cell phones may not be used for personal audio or video recording of office visits or in-lab testing.

EQUIPMENT RETURN

I understand that I am responsible to return any medical equipment that was loaned to me by Sleep Insights Medical Associates in a timely manner. All equipment should be returned within 1-2 weeks of receipt unless otherwise specified. I will be responsible for the full price of the unit it if it is not returned. This includes home sleep testing, oximetry, actigraphy and PAP loaner machines.

AUTHORIZATION TO ASSIGN BENEFITS TO GHALY SLEEP CENTER / SLEEP INSIGHTS MEDICAL ASSOCIATES PLLC

I authorize my Payer(s) to pay directly to Ghaly Sleep Center / Sleep Insights Medical Associates PLLC any benefits due under the terms of my health care plan(s), for services provided by Ghaly Sleep Center / Sleep Insights Medical Associates PLLC. I understand Ghaly Sleep Center / Sleep Insights Medical Associates PLLC reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Ghaly Sleep Center / Sleep Insights Medical Associates PLLC on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Sleep Insights Medical Associates PLLC.

AUTHORIZATION FOR TREATMENT

I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my physician(s) or other Ghaly Sleep Center / Sleep Insights Medical Associates PLLC medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physicians, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Sleep Insights Medical Associates PLLC to release all medical information as necessary to:

- All Payers* for processing health care claims;
- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Ghaly Sleep Center / Sleep Insights Medical Associates PLLC entities for the purpose of providing information regarding the services and goods of Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Sleep Insights Medical Associates PLLC may not condition treatment, payment, enrollment, or eligibility for benefits on my agreeing to this provision.

I authorize Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and my insurer(s) to share my past, current and future health, treatment and account records about services I have received from Ghaly Sleep Center / Sleep Insights Medical Associates PLLC and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

A health record locator service/health information exchange (HIE) allows my health care providers to electronically access my health information regarding my care and treatment held by other participating providers to provide me with better care. I authorize Ghaly Sleep Center / Sleep Insights Medical Associates PLLC to access any of my health information that is available in an HIE, including health information exchange organizations HealtheConnections, Surescripts, amongst other third party health information exchange organizations, and Ghaly Sleep Center / Sleep Insights Medical Associates PLLC will also make my Ghaly Sleep Center / Sleep Insights Medical Associates PLLC health information available through HIEs in which it participates unless I opt out. The third-party health information exchange organizations share health information electronically and meet the privacy and security standards of HIPAA and New York State Law. The choice I make in this section will not affect my ability to get medical care. I also have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. If I opt out, by checking the box below, Ghaly Sleep Center / Sleep Insights Medical Associates PLLC will exclude all of my Ghaly Sleep Center / Sleep Insights Medical Associates PLLC health information from the HIEs in which Ghaly Sleep Center / Sleep Insights Medical Associates PLLC participates.

[ ] HIE Opt Out

I have read, understand, and agree to the provisions of this Form. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. Ghaly Sleep Center / Sleep Insights Medical Associates PLLC reserves the right to change or amend this statement at any time and at its discretion.

X

Signature of Patient/Responsible Party	Print Name	Date

*For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

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SURESCRIPTS CONSENT FORM

I authorize Ghaly Sleep Center / Sleep Insights Medical Associates PLLC to electronically obtain access to my prescription history from participating pharmacies through the Surescripts network. This will assist Sleep Insights Medical Associates PLLC providers with prescribing, assessing health conditions and recommending appropriate treatment.

I hereby opt in of providing access to any health information available in a health information exchange.

Patient Signature **Date**

SLEEP INSIGHTS MEDICAL SERVICES LLC

Ghaly Sleep Center

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

POLICY STATEMENT **PLEASE REVIEW THIS NOTICE CAREFULLY.**

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes electronic protected health information, and which includes information about your condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

1. The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

(a) **Care** – In order to provide your care, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your condition and needs and provide advice or treatment (e.g., laboratory). For example, a physician treating you for a condition such as a sleep disorder may need to know what medications have been prescribed for you by the Practice's physicians.

(b) **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. The Practice may need to tell your

insurance plan about your condition so that the insurance plan can determine whether or not it will pay for the expense.

(c) **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

1. The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

(a) **De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.

(b) **Business Associate** – To a business associate, which is someone who the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g., billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) **Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) **Public Health Activities** - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.

(e) **Food and Drug Administration** - If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.

(f) **Abuse, Neglect or Domestic Violence** - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Practice believes that you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

(g) **Health Oversight Activities** - Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

(h) **Judicial and Administrative Proceeding** - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(i) **Law Enforcement Purposes** - In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

(j) **Coroner or Medical Examiner** - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

(k) **Organ, Eye or Tissue Donation** - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) **Research** - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

(m) **Avert a Threat to Health or Safety** - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(n) **Specialized Government Functions** - When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

(o) **Inmates** - The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

(p) **Workers' Compensation** - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(q) **Disaster Relief Efforts** – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

(r) **Required by Law** - If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

SIGN-IN SHEET

The Practice may use a sign-in sheet at the registration desk. The Practice may also call your name in the waiting room when your physician is ready to see you.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVE/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.

MARKETING

The Practice may only use and/or disclose your PHI for marketing activities if we obtain from you a prior written Authorization. "Marketing" activities include communications to you that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. However, marketing does not include, for example, sending you a newsletter about this Practice. Marketing also includes the receipt by the Practice of remuneration, directly or indirectly, from a third party whose product or service is being marketed to you. The Practice will inform you if it engages in marketing and will obtain your prior Authorization.

ON-CALL COVERAGE

In order to provide on-call coverage for you, it is necessary that the Practice establish relationships with other physicians who will take your call if a physician from the Practice is not available. Those on-call physicians will provide the Practice with whatever PHI they create and will, by law, keep your PHI confidential.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

(a) The Practice may use or disclose your PHI if you agree, or if the Practice provides you with opportunity to object and you do not object, or if the Practice can reasonably infer from the circumstances, based on the exercise of its judgment, that you do not object to the use or disclosure.

(b) If you are not present, the Practice will, in the exercise of its judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

(c) Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.

(e) Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason and support of

your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Complain to the Practice, or to the Secretary of Health and Human Services, Office of Civil Rights. You may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/regmail.html. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(i) To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer, Scott E. Blodgett, R.EEG T, at (585) 385-6070, or via email at sblodgett@sleepinsights.com.

PRACTICE'S REQUIREMENTS

1. The Practice:

(a) Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Practice's legal duties and privacy practices with respect to your PHI.

(b) Is required to abide by the terms of this Privacy Notice.

(c) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(d) Will not retaliate against you for making a complaint.

(e) Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

(f) Will post this Privacy Notice on the Practice's web site, if the Practice maintains a web site.

(g) Will provide this Privacy Notice to you by e-mail if you so request. However, you also have the right to obtain a paper copy of this Privacy Notice.

EFFECTIVE DATE

This Notice is in effect as of 7/18/05.

SLEEP INSIGHTS MEDICAL SERVICES LLC
Ghaly Sleep Center

PRACTICE'S HIPAA PRIVACY NOTICE

This Practice is obligated under HIPAA to protect the privacy of your protected health information ("PHI") and to provide you with a notice of its privacy practice (the "Privacy Notice").

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Practice's Privacy Notice bearing an effective date of July 18, 2005.

DISCLOSURE OF PHI TO DESIGNATED INDIVIDUALS

The Practice may disclose to a family member, other relative, or close personal friend, or any other person identified by you (the "Designated Individual"), your PHI directly relevant to that person's involvement with your care or the payment for your care. The Practice may also use or disclose your PHI to notify or assist in notifying (including identifying or locating) the Designated Individual, your Personal Representative, or another person responsible for your care, of your location, general condition or death. However, this can only occur if you agree to a disclosure to such persons.

If you wish to agree to such disclosures, please designate the family member, other relative, close personal friend, or any other person you wish to be your Designated Individual:

_____

CONSENT

I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written permission.

_____ _____

Name of Individual (Printed) Signature of Individual/ Date Signed

_____ _____

Signature of Personal Representative Relationship