Dear _____

You have an appointment with *Dr. Daniel Root* on _____ at _____am / pm. Thank you for considering Oregon Sleep Associates for the evaluation and treatment of your sleep concerns. In order to facilitate your care, we would like you to take a few minutes and carefully answer the questions in the enclosed forms to help us serve you better. Please remember to bring all insurance cards, photo ID, along with your co-pay. At the time of your consultation appointment, our staff will be taking a picture of you to be used in our electronic medical records system.

If you have not thoroughly completed your paperwork prior to your appointment, we will need you to arrive 20 minutes early for registration. Please do not bring children, as we do not provide childcare and they may not accompany you into the exam room. If needed, please bring your own language interpreter, we do not provide this service. If you require special assistance please make appropriate arrangements before coming to your appointment. If for any reason you need to reschedule your appointment, please call our office at least 24 hours in advance. For further questions please call (503) 288-5201.

We hope that you have a satisfying experience here and that all of your sleep health needs are met. We appreciate any feedback that you may have regarding your experience.

Thank you,

Oregon Sleep Associates Team

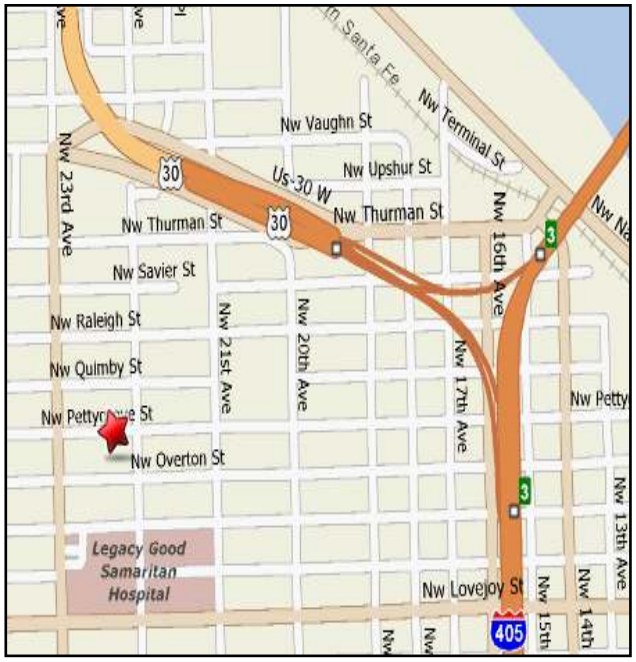
2228 NW Pettygrove Suite 150 • Portland, OR 97210 • Phone: 503.288.5201 • Fax: 503.288.0151

Directions

From *Gresham*:
Take I-84 West to I-5 North
Take the I-405 South/Hwy 30 exit
Cross Fremont Bridge follow to Vaughn St Exit
Turn left onto NW 23rd Ave
Turn left onto NW Pettygrove St

From *Vancouver*:
Take I-5 South towards Portland
Merge onto I-405/US-30 W exit 302B
Merge onto US-30 W exit 3 to NW Ind. Area
Merge onto US-30 W via the Vaughn St exit
Turn left at NW 23rd Ave
Turn left at NW Pettygrove St

From *Beaverton/Salem*:
Take the I-405 toward Hwy 30
Take Exit #3 toward Hwy 30
Take ramp right toward Vaughn.
Turn Left onto NW 23rd Ave
Turn Left onto NW Pettygrove St



Oregon Sleep Associates
2228 NW Pettygrove St, Suite 150
Portland, OR 97210
503-288-5201

Patient Information

Name: _____ DOB: ____/____/____
Last First MI

Address: _____
Street City State Zip

Social Security # ____-____-____ Home Phone: (____) _____ Cell Phone: (____) _____

Gender: ☐ M / ☐ F Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Other

Race:

☐ American Indian or Alaskan Native ☐ Asian

☐ Black/African American ☐ Caucasian/White

☐ Pacific Islander ☐ Decline/Refuse

☐ Other: _____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

☐ Decline/Refuse

Language:

☐ English ☐ Spanish ☐ Other: _____

Employer: _____ Work Phone: (____) _____

Employer's Address: _____
Street City State Zip

Preferred Pharmacy: _____ Address: _____

Responsible Party (If different from self)

Name: _____ DOB: ____/____/____
Last First MI

Relationship to patient: _____ SSN: ____-____-____ Sex: M / F

Address: _____
Street City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Employer's Address: _____
Street City State Zip

Emergency Contact

Name: _____ Contact Phone: _____

Insurance Information

Primary Insurance: _____ Policy # _____ Group ID # _____

Insurance Address: _____ Phone No.: _____

Policy Holder's Name: _____ DOB: ____/____/____ Relationship: _____

Employer: _____ Work Number: _____

Secondary Insurance: _____ Policy # _____ Group ID # _____

Insurance Address: _____ Phone No.: _____

Policy Holder's Name: _____ DOB: ____/____/____ Relationship: _____

Employer: _____ Work Number: _____

Referring Provider: _____ **Primary Care Provider:** _____

Have you received heath care under another name? **Y / N**
If yes, name used: _____

AUTHORIZATION FOR INSURANCE BENEFITAUTHORIZATION

IN CONSIDERATION FOR SERVICES RENDERED, I HEREBY AUTHORIZE DIRECT PAYMENT TO THE PHYSICIAN OR SUPPLIER; I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. IN ADDITION, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature: _____ Date: _____

Release of verbal Medical Information:

I. Permission to Verbally Discuss PHI with Family Members / Caregivers:
I hereby authorize medical providers and personnel of Oregon Sleep Associates to discuss my protected health information with the following person(s):

Name/Phone number:_____ Relationship:_____

Name/Phone number:_____ Relationship:_____

Name/Phone number:_____ Relationship:_____

-or- ☐ **I decline.** Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

II. Permission to Leave a Detailed Message:
I herby authorize the medical providers and personnel of Oregon Sleep Associates to leave a detailed message at the following **phone number:**_____

Appointment reminders only at phone: _____

Email: _____

-or- ☐ **I decline.** Please do not leave me detailed messages.

_____ _____
Signature of Patient/Personal Representative **Name of Patient/Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**

Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION			
Child's name:			Child's gender: ☐ Male ☐ Female
Child's birthdate:			Child's age:
Child's racial/ethnic background:	☐ White/Caucasian ☐ Native-American ☐ Other	☐ Black/African-American ☐ Hispanic-Latino	☐ Asian American ☐ Multi-racial

What are your major concerns about your child's sleep?
What things have you tried to help your child's problem?

SLEEP HISTORY	
Weekday Sleep Schedule	
Write in the amount of time child sleeps during a 24-hour period *on weekdays* (add daytime and night-time sleep):	_____ hours _____ minutes
The child's usual bedtime on *weekday nights*:	_____ : _____
The child's usual *waketime* on *weekday mornings*:	_____ : _____

Weekend/Vacation Sleep Schedule	
Write in the amount of time child sleeps during a 24-hour period *during weekends and vacations* (add daytime and nighttime sleep):	_____ hours _____ minutes
The child's usual bedtime on *weekend/vacation nights*:	_____ : _____
The child's usual *waketime* on *weekend/vacation mornings*:	_____ : _____

Nap Schedule
Number of *days each week* child takes a nap: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
If child naps, write in usual nap time(s): Nap 1: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m. Nap 2: _____ : _____ ☐ a.m. ☐ p.m. to _____ : _____ ☐ a.m. ☐ p.m.

General Sleep		
Does the child have a regular bedtime routine?	☐ yes	☐ no
Does the child have his/her own bedroom?	☐ yes	☐ no
Does the child have his/her own bed?	☐ yes	☐ no
Is a parent present when your child falls asleep?	☐ yes	☐ no

Child usually *falls asleep* in …	Child *sleeps most of the night* in …	Child usually *wakes in the morning* in …
☐ own room in own bed (alone)	☐ own room in own bed (alone)	☐ own room in own bed (alone)
☐ parents' room in own bed	☐ parents' room in own bed	☐ parents' room in own bed
☐ parents' room in parent's bed	☐ parents' room in parent's bed	☐ parents' room in parent's bed
☐ sibling's room in own bed	☐ sibling's room in own bed	☐ sibling's room in own bed
☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed	☐ sibling's room in sibling's bed

Child is usually put to bed by: ☐ Mother ☐ Father ☐ Both Parents ☐ Self ☐ Others
Write in the *amount of time* the child spends in *his/her bedroom* before going to sleep: _____ minutes

Child resists going to bed?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child has difficulty falling asleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child awakens during the night?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
After nighttime awakening, child has difficulty falling back to sleep?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child is difficult to awaken in the morning?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no
Child is a poor sleeper?	☐ yes	☐ no	**If yes**, do you think this is a problem?	☐ yes ☐ no

Current Sleep Symptoms						
	(a) never (does not happen)	(b) not often (less than 1 night/day a week)	(c) sometimes (1 to 2 nights/days a week)	(d) often (3 to 5 nights/days a week)	(e) always (6 to 7 nights/days a week)	(f) do not know
1. Difficulty breathing when asleep	a	b	c	d	e	f
2. Stops breathing during sleep	a	b	c	d	e	f
3. Snores	a	b	c	d	e	f
4. Restless sleep	a	b	c	d	e	f
5. Sweating when sleeping	a	b	c	d	e	f
6. Daytime sleepiness	a	b	c	d	e	f
7. Poor appetite	a	b	c	d	e	f
8. Nightmares	a	b	c	d	e	f
9. Sleepwalking	a	b	c	d	e	f
10. Sleeptalking	a	b	c	d	e	f
11. Screaming in his/her sleep	a	b	c	d	e	f
12. Kicks legs in sleep	a	b	c	d	e	f
13. Wakes up at night	a	b	c	d	e	f
14. Gets out of bed at night	a	b	c	d	e	f
15. Trouble staying in his/her bed	a	b	c	d	e	f
16. Resists going to bed at bedtime	a	b	c	d	e	f
17. Grinds his/her teeth	a	b	c	d	e	f
18. Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19. Wets bed	a	b	c	d	e	f

Current Daytime Symptoms						
	(a) never (does not happen)	(b) not often (less than 1 days a week)	(c) sometimes (1 to 2 days a week)	(d) often (3 to 5 days a week)	(e) always (6 to 7 days a week)	(f) do not know
1. Trouble getting up in the morning	a	b	c	d	e	f
2. Falls asleep in school	a	b	c	d	e	f
3. Naps after school	a	b	c	d	e	f
4. Daytime sleepiness	a	b	c	d	e	f
5. Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6. Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7. Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

PREGNANCY/DELIVERY											
Pregnancy	☐ Normal	☐ Difficult									
Delivery	☐ Term	☐ Pre-term	☐ Post-term								
Child's birthweight:											
Only child?	☐ Yes	☐ No	If no, circle birth order:	1st	2nd	3rd	4th	5th	6th	7th	

MEDICAL AND PSYCHIATRIC HISTORY			
PAST MEDICAL HISTORY			
Frequent nasal congestion	☐ Yes	Age of diagnosis:	
Trouble breathing through his/her nose	☐ Yes	Age of diagnosis:	
Sinus problems	☐ Yes	Age of diagnosis:	
Chronic bronchitis or cough	☐ Yes	Age of diagnosis:	
Allergies	☐ Yes	Age of diagnosis:	Allergies to what:
Asthma	☐ Yes	Age of diagnosis:	

Frequent colds or flus	☐ Yes	Age of diagnosis:
Frequent ear infections	☐ Yes	Age of diagnosis:
Frequent strep throat infections	☐ Yes	Age of diagnosis:
Difficulty swallowing	☐ Yes	Age of diagnosis:
Acid reflux (gastroesophageal reflux?	☐ Yes	Age of diagnosis:
Poor or delayed growth	☐ Yes	Age of diagnosis:
Excessive weight	☐ Yes	Age of diagnosis:
Hearing problems	☐ Yes	Age of diagnosis:
Speech problems	☐ Yes	Age of diagnosis:
Vision problems	☐ Yes	Age of diagnosis:
Seizures/Epilepsy	☐ Yes	Age of diagnosis:
Morning headaches	☐ Yes	Age of diagnosis:
Cerebral palsy	☐ Yes	Age of diagnosis:
Heart disease	☐ Yes	Age of diagnosis:
High blood pressure	☐ Yes	Age of diagnosis:
Sickle cell disease	☐ Yes	Age of diagnosis:
Genetic disease	☐ Yes	Age of diagnosis:
Chromosome problem (e.g., Down's)	☐ Yes	Age of diagnosis:
Skeleton problem (e.g., dwarfism)	☐ Yes	Age of diagnosis:
Craniofacial disorder (e.g., Pierre-Robin)	☐ Yes	Age of diagnosis:
Thyroid problems	☐ Yes	Age of diagnosis:
Eczema (itchy skin)	☐ Yes	Age of diagnosis:
Pain	☐ Yes	Age of diagnosis:
PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY		
Autism	☐ Yes	Age of diagnosis:
Developmental delay	☐ Yes	Age of diagnosis:
Hyperactivity/ADHD	☐ Yes	Age of diagnosis:
Anxiety/Panic Attacks	☐ Yes	Age of diagnosis:
Obsessive Compulsive Disorder	☐ Yes	Age of diagnosis:
Depression	☐ Yes	Age of diagnosis:
Suicide	☐ Yes	Age of diagnosis:
Learning disability	☐ Yes	Age of diagnosis:
Drug use/abuse	☐ Yes	Age of diagnosis:
Behavioral disorder	☐ Yes	Age of diagnosis:
Psychiatric Admission	☐ Yes	Age of diagnosis:
Please list any additional psychological psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist		

CURRENT MEDICAL HISTORY		
Please list any medications your child currently takes:		
Medicine	Dose	How often:
1.		
2.		
3.		
4.		

LONG-TERM MEDICAL PROBLEMS
If your child has long-term medical problems, please list the three you think are most important.
1.
2.
3.

SURGERIES/HOSPITALIZATIONS		
Has your child ever had his/her tonsils removed?	☐ Yes	Age of surgery:
Has your child ever had his/her adenoids removed?	☐ Yes	Age of surgery:
Has your child ever had ear tubes?	☐ Yes	Age of surgery:
Please list any additional hospitalizations or surgeries:		

HEALTH HABITS		
Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, iced tea)	☐ No ☐ Yes	Amount per day:

SCHOOL PERFORMANCE					
CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child's grade:					
Has your child ever repeated a grade?				☐ No	☐ Yes
Is your child enrolled in any special education class?				☐ No	☐ Yes
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing
Child's grades last year:	☐ Excellent	☐ Good	☐ Average	☐ Poor	☐ Failing

FAMILY'S INFORMATION

MOTHER	FATHER
Age	Age
Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried	Marital Status: ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed ☐ Remarried
Education:	Education:
Work: ☐ Unemployed ☐ Part-time ☐ Full-time	Work: ☐ Unemployed ☐ Part-time ☐ Full-time
Occupation:	Occupation:

PERSONS LIVING IN HOME

Name	Relationship	Age

FAMILY SLEEP HISTORY

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

If yes, mark the disorder(s):

Insomnia	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Snoring	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep apnea	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Restless legs syndrome	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Periodic limb movement disorder	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleepwalking/sleep terrors	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Sleep talking	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Narcolepsy	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent
Other:	☐ Mother	☐ Father	☐ Brother/sister	☐ Grandparent

REFERRAL

Who asked that your child be seen by a sleep specialist?

_____ Pediatrician/Family physician

_____ Child's parent or guardian

_____ Surgical specialist (e.g., ENT)

_____ Pediatric specialist (e.g., allergist, neurologist, pulmonologist

_____ Mental health specialist (e.g., psychiatrist, psychologist, social worker)

_____ School teacher, nurse, counselor

_____ Child himself/herself

Other:

Financial Policy

In order to assure that you receive every benefit to which you are entitled, we require your current insurance card, as well as any required referral or authorization, prior to each visit. If you have any questions regarding your insurance coverage prior to your visit, please call your insurance company and our office at **(503) 288-5201**.

You are required to pay any co-payment amount at the time of service. If you do not pay your co-pay, you may be assessed a fee of $25.00 per co-pay not paid. Additionally, you are responsible for the timely payment of your account balance for co-insurance, deductible and other items your insurance will not pay.

For your convenience we accept cash, checks, Visa and MasterCard. All patient balances are due within 30 days of our statement date, unless prior arrangements have been made with our billing department. A list of our fees is available upon request.

Insurance is a contract between you and your insurance company. We are not a party of this contract. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. **Failure to provide complete insurance information will result in patient responsibility for the entire bill**. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any amount unpaid by your insurance company becomes your responsibility.

Our office staff is always willing and available to discuss billing matters with you at any time. We know that you will agree that your clear understanding of our financial policy is important to our professional relationship. You may call the **Billing office** at (**503) 288-5201**.

As a patient, you are responsible to contact our office to re-schedule or cancel an office appointment and/or sleep lab appointment. Failure to cancel appointment on short notice or no show for appointment will result in a fee being assessed, per incident, on your patient account that will not be billed to insurance.

I have read, understand and agree to the terms of the above Financial Policy.

Patient Signature _____ Date _____

Effective Date: 7/25/2011

Oregon Sleep Associates
Notice of Privacy Practices
September 23rd, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care, and your family. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Continue Next Page

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Oregon Sleep Associates, LLC*. If you have questions and would like additional information, you may contact us at (503) 288 – 5201.

_____ _____

Patient Name please print Date

_____

Patient signature / Parent or Guardian