The Sleep Concierge, LLC

GENERAL PATIENT CONSENTS

The General Patient Consents include a Consent for Treatment, a Consent for Communication and Contact, and a Consent for Use and Disclosure of Protected Health Information and Acknowledgment of Notice of Privacy Practices. Please review all consents and the attached Notice of Privacy Practices and sign on page 3.

CONSENT FOR TREATMENT

I, the undersigned who is 18 years old or older, hereby authorize The Sleep Concierge, LLC and its health care providers and other staff members ("**Practice**"), to treat me, as deemed necessary to provide individual and group assessment and psychotherapy services related to sleep problems, and other related services as determined medically appropriated by the Practice. My Practice may use physician assistants, nurses, and other practitioners, including psychologists and psychiatrists, and I agree to be treated by such other practitioners. By signing below, I consent to treatment by the Practice.

I acknowledge that no guarantees or assurances have been made to me as the result of services, procedures, treatments, or evaluations through the Practice. I intend this consent to cover the entire course of treatment. I understand that any questions I may have regarding the potential side effects, complications, or outcome of any course of treatment or care may be directed to the Practice. I acknowledge by my signature below that although a good outcome is expected, and a reasonable effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained through any course of treatment or care.

I understand that the Practice does not take the place of a primary care provider ("PCP") and I agree to always maintain a PCP. I must provide information about my PCP to the Practice, which information should be provided with the Patient Information form I complete. If the Practice refers me to my PCP or a specialist for treatment, I agree to seek such care, and I understand that I may not continue receiving care by the Practice if I fail to seek such care from my PCP or a specialist.

I request and consent to be transported by Practice staff and/or emergency medical services to a hospital or emergency medical facility in the event of a medical emergency during the course of my treatment at the Practice.

CONSENT FOR COMMUNICATION AND CONTACT

I acknowledge that communications with the Practice using email, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. I accept the risk inherent in the use of any of the above-indicated communication methods for diagnoses, treatment, or any other healthcare or business-related reason. I expressly waive any obligation to guarantee confidentiality with respect to correspondence using such means of communication. I acknowledge that all such communications may become a part of my medical record.

I authorize the Practice to contact me according to the policies of the Practice regarding facets of my care, including requests for information, verification of payment, and reminders for appointments. I understand and accept that Practice may leave messages on home or cell phone answering systems or send reminder cards by U.S. mail, email or text message, according to the policies of the Practice.

If Practice needs to communicate with me regarding my treatment, my preferred method of communication is as follows (check one):

☐ Phone call _____ ☐ Email_____
☐ Text Message _____ ☐ Other _____

I understand that if I have chosen a phone call as my preferred method of communication, Practice may be required to leave a voicemail for me regarding my treatment. In such an event, Practice should (check one):

☐ Leave a message with detailed information regarding my treatment.
☐ Leave a message requesting that I call Practice at a specified phone number.

I understand that, from time to time, Practice may utilize email or text messages to communicate with me both about my treatment and for marketing purposes. I understand that these emails or text messages may include appointment reminders, general health reminders, feedback requests, newsletters and other information relating to Practice. Accordingly, I (check one):

☐ Authorize Practice to email or text me for both treatment and marketing purposes.
☐ Authorize Practice to email or text me appointment and health reminders only.
☐ Do not authorize Practice to email or text me.

I understand that this authorization will remain in effect until I either submit a subsequent authorization changing my above stated preferences or I revoke or withdraw this authorization in writing. To do so, I must send written notice to the Practice.

If offered by the Practice, I am responsible for utilizing the Practice's electronic medical record patient portal according to the instructions provided at the time of enrollment and for taking reasonable precautions to ensure no unauthorized access to my login information or confidential information. I agree not to access any information through the Practice's website regarding anyone other than myself and not to falsify or misrepresent identity or authority to act on behalf of another person. I must promptly notify the Practice of any change in contact information previously provided to the Practice.

I authorize the Practice and my provider to communicate information about my evaluations, treatment, results, and care to me and other individuals designated by me. If required by the Practice, I will provide those individuals with a password or other verification means. I acknowledge and agree that Practice and its employees, officers and physician assistants are released from any legal responsibility of liability for or resulting from the authorized disclosure of my health or billing information.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Practice has made available to me a Notice of Privacy Practices. I have the right to request a copy of the Notice of Privacy Practices prior to signing this consent. A current copy of the Notice is attached to this document as Attachment A and posted on the Practice's website at all times and may be printed from the website. The terms of the Notice of Privacy Practices may be revised or amended, and I have the right to request a current copy of the Notice of

Privacy Practices at any time. The Notice of Privacy Practices provides information about how the Practice may use and disclose Protected Health Information about me. The Notice of Privacy Practices contains a section explaining my rights regarding my Protected Health Information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly; Obtain payment from third-party payers, if applicable; and Conduct normal health care operations, such as quality assessments and physician assistant certifications. I acknowledge that I have been provided the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have the right to request that the Practice restrict or limit how Protected Health Information is used or disclosed for treatment, payment, or health care operations. I also understand the Practice is not required to agree to my requested restrictions, but if the Practice does agree, then it is bound to abide by such restrictions. I acknowledge that my medical information/records will be released to Practice. I further acknowledge that my medical information/records will be released from Practice to my primary care provider and referring/consulting providers.

By signing this General Patient Consents, I acknowledge that I have received a current copy of the Notice of Privacy Practices. At any time, I have the right to revoke this consent by submitting my request in writing and signed by me to the Practice.

I, the Patient, have received, reviewed, and consent to the General Patient Consents:

Patient Name **DOB** **Signature** **Date**

ATTACHMENT A

HIPAA Notice of Privacy Practices

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.**

Your Information. Your Rights. Our Responsibilities.

Your Rights	Your Choices	Our Uses and Disclosures
You have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the Practice's Office Manager. You may also send a written complaint to the U. S. Department of Health and Human Services the Practice's Office Manager will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.