ANCHORAGE SLEEP CENTER
510 W Tudor Rd Ste 5
Anchorage, AK 99503
(907) 743-0050 *phone*
(907) 743-0060 *fax*

WASILLA SLEEP CENTER
3719 E Meridian Lp Ste C
Wasilla, AK 99654
(907) 357-4200 *phone*
(907) 357-4201 *fax*

FAIRBANKS SLEEP CENTER
475 Riverstone Way #1
Fairbanks, AK 99709
(907) 374-9920 *phone*
(907) 374-9930 *fax*

SOUTHEAST SLEEP CENTER
2223 Jordan Ave
Juneau, AK 99801
(907) 500-7368 *phone*
(907) 500-7386 *fax*

PENINSULA SLEEP CENTER
43335 Kalifornsky Beach Rd Ste 25
Soldotna, AK 99669
(907) 420-0600 *phone*
(907) 420-0610 *fax*

PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Last name:		First name:	Middle name:
DOB:	SSN:	Sex: ☐ M ☐ F	Personal pronouns:
Mailing address:			
City:		State:	Zip:
Physical address:			
City:		State:	Zip:
Home phone:		Work phone:	Cell phone:
Email:			

GUARANTOR / LEGAL GUARDIAN INFORMATION

Only if patient has Power of Attorney or Guardianship. Legal documentation is required.

Last name:	First name:	Middle name:
DOB:	SSN:	Relationship:
Mailing address:		
City:	State:	Zip:
Home phone:	Work phone:	Cell phone:
Email:		

EMERGENCY CONTACT

Last name:	First name:	Relationship:
Cell phone:	Home phone:	Email:

To designate additional contacts for scheduling, treatment or billing matters, please fill out an Authorization to Release Health Information form.

INSURANCE INFORMATION

Primary Insurance:		
Policy holder name:		Policy holder DOB:
ID#:	Group#:	Relationship:
Secondary Insurance:		
Policy holder name:		Policy holder DOB:
ID#:	Group#:	Relationship:
Tertiary Insurance:		
Policy holder name:		Policy holder DOB:
ID#:	Group#:	Relationship:

The above information is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days of receipt of statement, unless other arrangements are made with this office, in advance. I authorize the physicians and Anchorage Sleep Center, LLC to release any information required to process my insurance claims. I also authorize payment of insurance benefits directly to Anchorage Sleep Center, LLC.

Signature:		**Date:**	
Printed Name (Patient or Authorized Representative):			

PERSONAL HEALTH HISTORY

Patient Name:	**DOB:**	**Today's Date:**

SOCIAL HISTORY

Marital status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other			# of Children:	
Occupation:					
Employer:			Licensing required: ☐ DOT ☐ FAA ☐ Maritime		☐ No
Tobacco use:	☐ Yes ☐ No ☐ Former	How long: Yrs	Packs/day:	Date quit:	
Alcohol use:	☐ Yes ☐ No ☐ Former	☐ Beer ☐ Wine ☐ Hard liquor	# of drinks per ☐day ☐week	Date quit:	
Coffee use:	☐ Yes ☐ No	Cups per day:	Energy drinks: ☐Yes ☐No	Cups per day:	
Cannabis use:	☐ Yes ☐ No	How often:			
Recreational drug use:	☐ Yes ☐ No ☐ Former	Type/Frequency:		Date quit:	
		Type/Frequency:		Date quit:	
		Type/Frequency:		Date quit:	

MEDICAL HISTORY

Diagnosis	Self	Family Member	Diagnosis	Self	Family Member	Diagnosis	Self	Family Member
Cardiovascular			**Genitourinary**			**Skin**		
Abnormal ECG			Chronic kidney disease			Acne		
Anemia			HIV/AIDS			Eczema		
Arrhythmia			Kidney stones			Psoriasis		
Chest pain			UTI			Rosacea		
Congestive heart failure			Venereal disease			Skin disease		
Coronary artery disease								
Heart valve abnormalities			**Mental Health**			**Sleep**		
High cholesterol			Anxiety			Insomnia		
Hypertension			Depression			Restless leg syndrome		
						Sleep apnea		
Ear/Eye Health			**Musculoskeletal**					
Cataracts			Arthritis			**Men**		
Ear infections			Fractures			Prostate problems		
Glaucoma			Gout					
Hearing loss/Tinnitus			Joint replacement			**Women**		
Visual impairment						Menstrual abnormalities		
			Neurological			Other:		
Endocrine			Migraines/Headaches					
Diabetes			Polio			**Autoimmune (List)**		
Thyroid disease			Seizure disorder					
			Stroke					
Gastrointestinal								
Crohn's/Ulcerative colitis			**Pulmonary/Respiratory**			**Cancer or Other Diagnoses (List)**		
Gallstones			Asthma					
GERD			Chronic lung disease					
Hemorrhoids			Emphysema/COPD					
Hepatitis			Pneumonia					
IBS/Constant diarrhea			Pulmonary embolism/DVT					
Liver disease			Tuberculosis					
Stomach duodenal ulcer								

HOSPITALIZATION & SURGICAL HISTORY

List	Date	List	Date

FAMILY HISTORY

LIST OF ARTIFICIAL DEVICES (glasses, pacemaker, hearing aids, etc.)

LIST OF ALLERGIES (including medication allergies)

CURRENT MEDICATIONS (prescribed and non-prescribed)

Name of Drug	Dose (strength & # pills/day)	Name of Drug	Dose (strength & # pills/day)

SLEEP SURVEY

Patient Name:		**DOB:**	**Today's Date:**
Referral source:	☐ Provider ☐ Family ☐ Friend ☐ Other	Height:	Weight:
Referring provider:		Primary care provider:	
Main sleep complaint:			

SLEEP HABITS

What time on weekdays do you usually?		Go to bed:	Wake up:
What time on weekends do you usually?		Go to bed:	Wake up:
What are your usual work hours *(if applicable)*?		Begin:	End:
How long does it take you to get to sleep?		Minutes:	
How often do you wake up at night?		Times:	
How long to return to sleep?		Minutes:	
Does anyone tell you that you snore?		☐ Yes ☐ No	
Do you feel rested upon awakening?		☐ Yes ☐ No	
Do you awaken with racing thoughts or anxiety?		☐ Yes ☐ No	
Do you have vivid dreams as you are falling asleep?		☐ Yes ☐ No	
Are you bothered by sleepiness during the day?		☐ Yes ☐ No	
Do you experience crawling sensations in your legs prior to sleep?		☐ Yes ☐ No	How often:
Do you awaken with headaches?		☐ Yes ☐ No	How often:
Do you awaken with a bitter or sour taste in your mouth?		☐ Yes ☐ No	How often:
Do you experience abnormal sleep behavior?		☐ Yes ☐ No	How often:
Do you take a nap during the day?	☐ Yes ☐ No	How long:	How often:
Have you previously had a sleep study?		☐ Yes ☐ No	
When:	Where:		
Have you previously been prescribed PAP therapy?		☐ Yes ☐ No	
When:	Where:		

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

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

Situation	**Chance of Dozing**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for one 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 *(without alcohol)*	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3
Total Score				

Other Concerns:

BED PARTNER QUESTIONNAIRE

Patient Name:	**DOB:**	**Today's Date:**
Name of person completing this questionnaire:		
I have observed this person's sleep:	☐ Never ☐ Once or twice ☐ Often ☐ Every night	

Check any of the following behaviors you have observed this person doing while sleeping:

☐ Light snoring	☐ Twitching/Kicking	☐ Head rocking/banging	☐ Choking
☐ Loud snoring	☐ Crying out	☐ Sitting up not awake	☐ Pauses in breathing
☐ Biting tongue	☐ Sleepwalking	☐ Occasional loud snorts	☐ Grinding teeth
☐ Very rigid/Shaking	☐ Bedwetting	☐ Getting out of bed not awake	
☐ Other:			

Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

If this person snores, what makes it worse?	☐ Sleeping on back ☐ Sleeping on side ☐ Alcohol ☐ Fatigue	
Does the snoring sometimes require you and your partner to sleep separately?		☐Yes ☐No

Has this person ever fallen asleep during normal daytime activities or in dangerous situations?	☐Yes ☐No
If yes, please explain:	

Does this person use sleeping pills?		☐ Yes ☐ No
If yes, how many times per week?	☐ Less than one ☐ 1-3 ☐ 4-6 ☐ Every night	
Do you consider this usage a problem?		☐ Yes ☐ No
Comments:		

Does this person drink alcohol?		☐ Yes ☐ No
If so, what type?	☐ Beer ☐ Wine ☐ Liquor	
Estimate how many drinks per day/week:		
Estimate how much this person drinks three hours before bed:		
Do you consider this person to have a drinking problem?		☐ Yes ☐ No
Comments:		

If this person uses recreational drugs, please describe the frequency of usage:
Comments:

Do you believe this person and yourself share the same understanding about his/her sleep problem(s), sleeping pill usage and alcohol/drug use?	☐ Yes ☐ No

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GENERAL POLICIES

Anchorage Sleep Center, LLC offers sleep diagnostic and treatment services for patients across Alaska, with direct presence in Anchorage, Fairbanks, Wasilla, Juneau and Soldotna, and remote services for patients in other locations. We are committed to delivering state-of-the-art sleep medicine care in a pleasant and comfortable environment, with courtesy and attention to patients' individual needs and in close collaboration with referring providers. We take pride in being your chosen provider and encourage your feedback as we strive to provide the highest quality of service and care to our patients. Prior to becoming our patient, it is important that you review and understand our general and financial policies and provide complete information as requested in the enclosed patient registration forms.

CONSENT TO MEDICAL TREATMENT

I, the undersigned, hereby consent to and permit Anchorage Sleep Center, LLC, its providers, employees, and other persons caring for me (or the patient listed below) to provide treatment, diagnostic procedures and other health and medical services as may be deemed necessary and available to me (or the patient listed below) during the period of care. I understand that the patient care is under the control of healthcare providers who are independent practitioners. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me (or the patient listed below) as to the result of examination or treatment at Anchorage Sleep Center, LLC. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

PATIENT'S RIGHTS

You have the RIGHT to:

- Receive accurate and easily understood information about the patient's proposed health care and the providers of such care. If the patient speaks another language, has a physical or mental disability, or just doesn't understand something, help should be given so that the patient can make informed health care decisions.
- Know treatment options and take part in decisions about care. Parents, guardians, family members, or others can speak for the patient, if the patient cannot make his/her own decision.
- Receive considerate, respectful care from doctors and other healthcare providers that does not discriminate against the patient.
- Talk privately with healthcare providers and to have healthcare information protected.
- Read and copy your own medical record and ask that your doctor change the record if it is not correct, relevant, or complete.
- Examine and receive a detailed explanation of any medical bill and the information regarding financial assistance that may be offered.

PATIENT'S RESPONSIBILITIES

You have the RESPONSIBILITY to:

- Provide your current health insurance details, including primary, secondary and tertiary coverage, and promptly report any change or termination of your health insurance coverage.
- Provide Anchorage Sleep Center, LLC with any change in demographic information.
- Provide, to the best of your knowledge, accurate and complete information concerning your medical history, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Tell your doctor about any change in your condition or if problems arise.
- Tell your doctor if you do not understand your treatment or what you are expected to do.
- Accept financial responsibility for payment of services, pay your bill promptly or inform Anchorage Sleep Center, LLC if you are unable to pay your bill.
- Follow the recommended plan of treatment or assume responsibility for your actions if the treatment is refused.
- Adhere to the office rules, be respectful to other patients and staff, be considerate of their rights and personal property and the property of the clinic.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

By signing below, I acknowledge that I have reviewed and agree to the Anchorage Sleep Center, LLC's Notice of Privacy Practices that describes how my (or the patient's health information) is used and shared. I understand that I am entitled to receive a copy of the Anchorage Sleep Center, LLC's current Notice of Privacy Practices at any time.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize Anchorage Sleep Center, LLC to disclose all or any part of my record, and any other information in its possession, to any other parties related to my care, including, but not limited to, insurance companies and worker's compensation carriers. I hereby release Anchorage Sleep Center, LLC from all legal responsibility or liability, which may arise from disclosure of my record as provided in this paragraph. I hereby authorize Anchorage Sleep Center, LLC to furnish requested information excerpts from my record to any insurer, its intermediary or another healthcare facility to provide continuity of care. Anchorage Sleep Center, LLC may periodically participate in statistical research studies. I agree that statistical information can be released on an anonymous/confidential basis. I understand that Anchorage Sleep Center, LLC keeps a record of the health care services provided and that I may review my record (a 24-hour notification is required). I may request a copy of all or any part of my record, (there is a charge for this service), and I may ask Anchorage Sleep Center, LLC to correct that record. Except as noted above, Anchorage Sleep Center, LLC will not disclose my record unless I direct them to do so, or the law authorizes or compels them.

CANCELLATIONS AND MISSED APPOINTMENTS

Our office schedules appointment times specifically for you. If you must reschedule or cancel your appointment, please contact our office at least 24 hours in advance. A cancellation fee of $50.00 for day-time appointments and $250.00 for in-lab sleep studies may be charged for late cancellations or appointments missed without prior notice. This charge is NOT billable to your insurance payer and is the responsibility of the patient (or guarantor) to pay. Multiple short-notice cancellations may result in our inability to schedule future appointments. All scheduling matters should be directed to the individual offices: Anchorage 907-743-0050 / Wasilla 907-357-4200 / Fairbanks 907-374-9920 / Southeast 907-500-7368 / Peninsula 907-420-0600 during normal business hours Mon-Fri 9:00am – 5:00pm.

WAITING LIST FOR SERVICES

If you would like to schedule an appointment for a day or time that is not available, please let us know and we will place you on our waiting list. If another patient cancels their appointment or additional dates and times become available, we will contact patients on the waiting list on a first-come-first-serve basis.

CONSENT TO RECORD AUDIO/VIDEO FOR INLAB SLEEP TESTING

I understand that during the course of my sleep study, I may be video/audio taped by the sleep technologist. I hereby authorize the use of this video/audio for the sole purpose of medical diagnosis and treatment. This video will NOT be distributed or shared for any purpose, unless requested under applicable law.

PHOTOGRAPHS

The taking, reproduction and use of photographs in connection with my diagnosis, care and treatment at Anchorage Sleep Center, LLC for purposes of scientific and medical study and research is approved, provided my identity is not revealed. Photographs may include the use of video tapes and television.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your caregiver experience a situation that requires the attention and resolution of a supervisor and/or manager, please contact our practice either by phone or in writing. Our Manager/Business Owner will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for Anchorage Sleep Center, LLC to provide me medical services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

FINANCIAL POLICY

Our practice participates with Medicare, Medicaid, and other healthcare insurance plans. As a courtesy to you, we will file insurance claims for services on your behalf. Patients are responsible for deductibles, co-payment and co-insurance amounts, non-covered services, and out-of-network services. For non-insured patients, please contact our staff to make payment arrangements.

Please be prepared to provide a current copy of your insurance and ID card(s) at each visit. It is the patient's responsibility to know and understand their insurance benefits and verify the in-network vs out-of-network status of the healthcare provider. If at any point your insurance policy changes, terminates or cancels coverage, you will be fully responsible for all charges that cannot be rebilled to the new insurance provided. Most insurance(s) have different requirements for prior-authorizations and timely filing requirements, and if they are not met, we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy.

Our Billing Department can obtain a general breakdown of your insurance benefits from your insurance carrier. This information can be provided to you upon request. This information is not a guarantee of benefits; all claims are subject to processing by the insurance and its medical guidelines and policies, pre-authorization requests, appeals, and various factors that are out of our control.

Our office accepts cash, checks, money orders and credit card payment. Following the receipt of your monthly patient statement, please contact our Billing Department if you need to discuss a payment arrangement. We are willing to negotiate reasonable payment plans to keep your account current.

If you have inquiries about your claims, monthly statements, other billing matters, or if you have healthcare coverage updates, please contact our Billing Department at 907-743-0080 Mon-Fri 8:00am-4:00pm.

WORKER'S COMPENSATION

If you are being treated for a work-related condition, please complete our worker's compensation verification form so that we may submit needed authorizations and claims on your behalf.

INTEREST CHARGES ON PATIENT BALANCES

Our practice charges interest on unpaid account balances. If we receive a payment on your account from either you or your healthcare insurance payer within 30 days, no interest charges will be applied to your account.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients to resolve past due accounts in all cases. If we cannot reach a patient by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

AUTHORIZATION OF PAYMENT

I hereby authorize payment of medical benefits directly to Anchorage Sleep Center, LLC for services rendered to me during the period of my care. If my health insurance plan will not direct payment to ASC, I agree to forward to ASC all health insurance payments which I receive (or the patient receives) for the services rendered by ASC. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize the release of information as may be necessary for purpose of treatment, payment and operations such as credentialing, peer review, accreditation and compliance with state and federal laws. I authorize ASC to file an appeal on my (or the patient's) behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I permit a copy of this authorization to be used in place of the original.

MEDICARE AUTHORIZATION (For Medicare patients only)

I hereby request that payment of Medicare benefits be made on my behalf to Anchorage Sleep Center, LLC for services rendered to me by that physician, clinic or supplier. I authorize any holder of Medicare information about me to be released to the Centers for Medicare Services (CMS) and its agents, including information needed to determine the benefits payable for related services.

FINANCIAL AGREEMENT

By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying Anchorage Sleep Center, LLC for the services provided to you.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

Printed Name (Patient or Authorized Representative): _____

ANCHORAGE SLEEP CENTER WASILLA SLEEP CENTER FAIRBANKS SLEEP CENTER SOUTHEAST SLEEP CENTER PENINSULA SLEEP CENTER

NOTICE OF PRIVACY PRACTICES

As required by privacy regulations created as a result of the Health Insurance Portability/Accountability Act of 1996, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE READ CAREFULLY. Within this document the patient is referred to as "you". If you are a parent or legal guardian of the patient, reading this notice will inform you of our policies regarding the patient's medical information and how it will be handled.

COMMITMENT TO PRIVACY:

Our practice is committed to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of your health information. We are also required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our office concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect.

We recognize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure regarding your PHI.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your PHI for treatment purposes. We may disclose your PHI to other health care providers for purposes related to your treatment. This may include, but is not limited to, your doctor, other providers, caseworkers, and school related personnel.
2. **Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs.
3. **Health Care Operations.** Our practice may use and disclose your PHI to operate our business. An example of this is using your PHI to evaluate the quality of care you receive from us.
4. **Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. An example of this is leaving a message on your answering machine.
5. **Release of Information to Family/Friends**. Our practice may release your PHI to a friend or family member that is involved in your care. For example, if a friend, babysitter, grandparent, or other family member brings you or your child to the clinic for care, they may receive medical information about you or that child.
6. **Disclosures Required by Law –** Our practice will use and disclose your PHI when we are required to do so by federal, state, and/or local law.

USES AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. **Public Health Risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of reporting child abuse or neglect, maintaining vital records, preventing or controlling disease, injury or disability, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting problems with products or devices, notifying individuals that a product or device they may be using has been recalled, or notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities**. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities may include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your PHI in response to a court order, if you are involved in a lawsuit or similar proceedings.
4. **Law Enforcement.** Our practice may release PHI if asked to do so by a law enforcement official: regarding a crime victim in certain circumstances if we are unable to obtain the person's consent; concerning a death/injury we believe has resulted from criminal conduct; regarding criminal conduct at our offices; in response to a warrant, summons, court order, or similar legal process; to identify/locate a suspect, material witness, fugitive or missing person; or in an emergency, to report a crime.
5. **Serious Threats to Health and Safety**. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to you or your child's health and safety or the health and safety of another individual.
6. **Military.** Our practice may disclose your PHI if you are a member of US or foreign military forces and if required by the appropriate authorities.
7. **National Security**. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials, foreign heads of state, or to conduct investigations.
8. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials, if you or your child is an inmate or under the custody of law enforcement officials. Disclosure for these purposes would be necessary for the institution to provide health care service to you or your child, for the safety and security of the institution and to protect your health and safety or the health and safety of other individuals.
9. **Worker's Compensation**. Our practice may release your PHI for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding the PHI that we maintain about you (the patient). Requests involving your rights must be submitted in writing.

1. **Request Confidential Communications**. You have the right to request that our clinic communicate with you about health-related issues in a particular manner, or at a certain location. The request must specify the method of contact, or the location where you wish to be contacted. We will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion the information you wish restricted, whether you are requesting to limit our practice's use, disclosure or both, and to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you or your child, including patient medical records, and billing records. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete. You may request an amendment as long as the information is kept by, or for our practice. You must provide us with a reason that supports your request for the amendment. Also, we may deny your request if you ask us to amend information that is in our opinion accurate and complete, not part of the PHI, not created by our clinic, or the individual/entity that created the information is not available to amend the information.
5. **Accounting of Disclosure**. All of our patients have the right to request on "accounting of disclosures" which is a list of certain non-routine disclosures our clinic has made of your PHI for non-treatment, non-payment, or non-operations purposes. Use of your PHI as part of the routine patient care in our clinic is not required to be documented. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 15, 2003.
6. **Paper Copy of this Notice**. You are entitled to receive a paper copy of this notice of privacy practices at any time. A written request is not required.
7. **File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with Anchorage Sleep Center's Privacy Officer, the Office of Civil Rights, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosure.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your or your child's PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in this authorization. Please note we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy practices, please contact our **Privacy Officer at 907-743-0050**.