PEDIATRIC
SLEEP SPECIALISTS
Infants • Children • Adolescents

Adult Transition Medical Care Consent Form

This form is designed for patients approaching their 18th birthday or those who have recently turned 18. Upon reaching the age of 18, you are legally considered an adult and are responsible for making your own medical decisions. This form allows you to designate a parent, guardian, or another individual access to your medical records and to discuss your care with medical providers.

Patient Information:

Name: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

Phone Number: _____

Email Address: _____

Designated Individual(s) for Medical Information Access

You may designate one or more individuals to have access to your medical information. Please fill out the information below for each person you wish to grant access to.

1. Name: _____

- Relationship to Patient: _____
- Phone Number: _____
- Email Address: _____

2. Name: _____

- Relationship to Patient: _____
- Phone Number: _____
- Email Address: _____

3. Name: _____

- Relationship to Patient: _____
- Phone Number: _____
- Email Address: _____

4. Name: _____

- Relationship to Patient: _____
- Phone Number: _____
- Email Address: _____

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Consent for Access to Medical Records and Discussion of Care

- I hereby grant the individual(s) named above access to my medical records and permit them to discuss my medical care with healthcare providers as specified below. This consent includes access to medical records, the ability to make appointments, and discuss treatment options and medical decisions on my behalf.

☐ Full access to medical records and discussions about medical care.

☐ Limited access to medical records and discussions about specific medical issues only, as detailed below:

_____

_____

_____

Privacy and Revocation

- I understand that I have the right to revoke this consent at any time by providing written notice to my healthcare provider. I also understand that the information disclosed to my designated individual(s) may no longer be protected by federal privacy regulations (HIPAA) once disclosed.

Patient's Signature: _____ **Date:** _____

Witness Signature (Optional): _____ **Date:** _____

Office Use Only

Received by: _____

Date: _____

Notes: _____

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FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name: _____ Patient Date of Birth: _____

Pediatric Sleep Specialists ("PSS") makes every effort to verify your insurance benefits before your appointment. Verification of eligibility and benefits does not guarantee that your insurance will pay claims. The benefits and fees provided to you are only an estimation of cost. Final charges will be based on actual services provided and claims processing. PSS is not responsible for any incorrect or misinformation provided to us by your insurance company regarding benefit verification. Actual benefits cannot be determined by PSS but will be applied by your insurance carrier when the claim is processed.

Not every service recommended by your provider is covered by your insurance. It is your responsibility to know what is or is not covered, policy limitations, and referral and authorization requirements. By signing this financial policy, you understand and agree to be responsible for paying any services that are not paid by your insurance company.

PSS is in-network with most major network carriers. We are a participating provider with Medicaid of Colorado. If you do have an out-of-network insurance, we will gladly file your claims for you as a courtesy, providing you have out-of-network benefits. However, we do not file claims to payers when there are no out-of-network benefits available unless otherwise notified. It is your responsibility to know your benefits, both in and out-of-network, prior to scheduling an appointment with our practice. For a list of our network providers and to whom we will file claims, please contact the Billing Department at (800) 506-8933.

Children of divorced parents: Responsibility for payment of treatment of minor children whose parents are divorced rests with the parent who seeks the treatment. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of PSS.

It is your responsibility to notify PSS immediately of any change in insurance status. Failure to report changes timely will result in transferring the balance of any unpaid claims to you. Regardless of insurance status, if your insurance does not pay, fails to pay timely, or denies a claim, you will be responsible for the charges incurred.

You are expected to pay any copay, coinsurance, deductible, or balance due on your account prior to receiving any services. Failure to do so may result in your appointment being rescheduled.

PSS offers a prompt payment discount to patients who do not have insurance and who pay in full at or before the time of service. Prompt payment discounts cannot be applied to copays or deductibles. Patients paying at the time of visit should be aware that additional charges related to the visit may be billed later.

PSS requires a 24-hour notice to cancel an appointment. If you fail to cancel an appointment within the 24- hour timeframe, you may be charged a $50.00 No Show Fee.

PSS offers the opportunity to establish a reasonable payment plan if you cannot pay in full at the time of service. If you have an outstanding balance, we expect you to make a payment or payment arrangements before your next scheduled appointment.

PSS will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, you must contact our office within 30 days after receiving the initial statement. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, PSS may begin various collection activities including, but not limited to submitting the past due account to a collection agency.

PSS firmly believes that a good patient/provider relationship is based upon understanding and open communications. We hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies, please call us at (800) 506-8933.

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FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

AGREEMENT OF FINANCIAL POLICY

I have read and understand the financial policy of PSS and agree to abide by the terms therein.

Signature of Patient/Legal Guardian: _____ Date: _____

Relationship to patient: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Pediatric Sleep Specialists to release any information required to obtain authorization or process a claim for services rendered to my insurance company. I hereby authorize that payment of benefits by my insurance company be made directly to Pediatric Sleep Specialists.

Signature of Patient/Legal Guardian: _____ Date: _____

Relationship to patient: _____ Date: _____

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CONFIDENTIAL COMMUNICATION FORM

To protect your privacy, Pediatric Sleep Specialists ask that you complete this form so we know the ways we may communicate with you regarding your health information. Please mark below what you feel comfortable with, so we have multiple ways to communicate with you regarding your health care. **PLEASE PRINT**

Patient Name:_____ Date of Birth:_____

Primary Phone: ☐ Cell Phone ☐ Home Phone

Cell Phone #:_____ Home Phone # (if different): _____

I prefer to receive my appointment reminder in the following method: ☐Text Message ☐Phone Call

I authorize Pediatric Sleep Specialists, providers, and employees to do the following:

Yes No	Leave a message at my cell/home number regarding appointment reminders or scheduling ***It is important to always keep your cell/home number updated with Pediatric Sleep Specialists***
Yes No	Send me a letter in the mail regarding appointment reminders, test results and /or scheduling needs
Yes No	Leave my test results in a message at my cell/home number

I authorize Pediatric Sleep Specialists to discuss my healthcare, as indicated with the following individuals:

Name:			Name:			Name:		
Relationship:			Relationship:			Relationship:		
Phone:			Phone:			Phone:		
Yes	No	Appointment Reminders	Yes	No	Appointment Reminders	Yes	No	Appointment Reminders
Yes	No	Make or Attend Appointments	Yes	No	Make or Attend Appointments	Yes	No	Make or Attend Appointments
Yes	No	Test Results	Yes	No	Test Results	Yes	No	Test Results
Yes	No	Billing Information	Yes	No	Billing Information	Yes	No	Billing Information

If applicable, minor children's school excuses may be released as needed to the following schools and/or daycares:

Emergency Contact: Name:_____ Phone Number:_____ Relationship:_____

Pediatric Sleep Specialists conducts Patient Satisfaction Surveys at random. If chosen to receive the survey, you will receive a text message to share your opinion regarding your recent experience at our clinic. Please note text message rates may apply.

Yes No	I consent to receiving text messages regarding my recent experience.

I understand that I have the right to change or cancel this request at any time by notifying the Privacy Officer, in writing, at Pediatric Sleep Specialists, Attention Privacy Officer, 9235 N. Union Blvd, Ste 150-334, Colorado Springs CO. 80920-7833. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation.

I also hereby acknowledge that I received Pediatric Sleep Specialists Notice of Health Information Privacy Practices.

_____ _____

Signature of Patient/Representative and Date Printed Name of Patient/Representative

_____

Relationship to Patient

Expiration: To be updated yearly

Northern Colorado: 970-527-1122 • Fax: 970-527-1123
Southern Colorado: 719-638-1122 • Fax: 719-638-1123

Loveland • Greeley • Windsor
Colorado Springs • Woodland Park
www.pediatricsleepspecialists.com

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Medical Records Release Authorization Form

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party: _____to use or disclose the following health information.

☐ – All of my health information

☐ – My health information relating to the following treatment or condition: _____

☐ – My health information covering the period from _____ (date) to _____ (date)

☐ – Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone_____ Fax _____ Email _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I have the right to receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____

If the patient is a minor or unable to sign, please complete the following:

☐ – Patient is a minor: _____ years of age

☐ – Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name and relationship of Authorized Representative: _____

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INFORMED CONSENT for TELEMEDICINE SERVICES

PATIENT NAME:	DATE OF BIRTH:	MEDICAL RECORD #:	DATE CONSENT DISCUSSED:

INTRODUCTION:

Telemedicine involves the use of electronic communications and information by health care providers to deliver services to an individual when he/she is at a different site than the provider. The information may be used for consultation, diagnosis, therapy, follow-up and/or education.

The laws that protect privacy and the confidentiality of medical information also apply to telemedicine. Systems used will incorporate security protocols to protect the confidentiality of patient identification and medical data and will ensure the integrity against intentional and unintentional corruption.

POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telemedicine. This could include:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician/provider.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

CONSENT:

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I will have access to all medical information from the telemedicine services, under state law.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Pediatric Sleep Specialists (PSS) at 719-638-1122. As long as this consent is in force (has not been revoked) PSS may provide health care services for me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer, relationship to patient: _____

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pediatricsleepspecialists.com

NOTICE OF HEALTH INFORMATION 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.

Pediatric Sleep Specialists ("PSS") is required by law to maintain the privacy of your health information and is strongly committed to maintaining your privacy. PSS is required to provide you a Notice explaining our legal duties and privacy practices. PSS will not use or disclose your health information except as described in this Notice. PSS is required to notify affected individuals following a breach of unsecured health information. This Notice applies to all of the health information generated by PSS, as well as information we receive from others, including health care providers and health plans.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

TREATMENT: We may use and disclose your health information to provide and coordinate your health care treatment. We may disclose all or part of your health information to your attending physician, consulting physicians, nurses, or other health care providers and personnel who have a legitimate need for such information. PSS may also use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

PAYMENT: We may use and disclose health information about you for billing purposes, including obtaining authorization for treatment, billing insurance, third party, or other entity involved in the payment of your medical bill. We may be required to provide copies or excerpts of your medical record for payment review. For example, we may send a claim for payment, and it will have a code that describes the services we provided.

HEALTHCARE OPERATIONS: We may use and disclose health information about you for our healthcare operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. We may need to use or disclose your medical information to assess the quality of care you receive, conduct cost management, business management, and administrative or quality improvement activities. PSS may engage outside companies ("business associates") to carry out certain aspects of these healthcare operations. PSS may need to disclose your health information to the business associates to enable them to perform their duties. For example, business associates might be third party billing companies, accountants, and lawyers. PSS will require the business associate to sign an agreement to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

PSS will obtain a written authorization from you before it uses or disclosed your protected health information unless a particular use or disclosure is expressly permitted or required by law without your permission. We must obtain your authorization to use or disclose your protected health information for certain marketing purposes, fundraising, or selling your information. You have the right to revoke any authorization previously given by submitting a written request to PSS. However, we cannot undo any uses or disclosures we have already made based on your previous consent.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

PSS may disclose your health information to a friend or family member involved in your medical care, who helps pay for your care, and for disaster relief purposes. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT AUTHORIZATION

REGULATORY AGENCIES: PSS may disclose your health information to government and certain private health oversight agencies, such as the Department of Public Health and Environment, the Joint Commission, or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations, and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT, NATIONAL SECURITY, INTELLIGENCE, AND LEGAL ACTIVITIES: PSS may disclose your health information to law enforcement officials if necessary, to prevent or decrease a serious and imminent threat of injury to your physical, mental, or emotional health or safety of the physical safety of another person. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. PSS may disclose your health information for judicial and arbitration proceedings and other disputes consistent with applicable law.

PUBLIC HEALTH: As required by law, PSS may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

WORKERS' COMPENSATION: PSS may disclose health information about you for workers' compensation or similar program. These programs provide benefits for work-related injuries.

MILITARY/VETERANS: If you are a member of the armed forces, we may use and disclose health information about you as required by the appropriate military authorities.

THE EFFECTIVE DATE: The effective date of this Notice is October 15, 2018

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

CORONERS/MEDICAL EXAMINERS/FUNERAL HOME DIRECTORS: We may disclose your health information to a coroner or medical examiner for purposes of identifying a deceased person or to determine the cause of death. We may also release health information about you to funeral home directors as necessary to carry out their duties.

RESEARCH: PSS may use and disclose your health information for reviews preparatory to research and if approved by a privacy board or institutional review board for research studies.

AS OTHERWISE REQUIRED BY LAW: PSS will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse, or the prevent harm to you or other individuals).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION

Although all records concerning your treatment obtained at PSS are the property of PSS, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request PSS only at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information in paper and electronic format, except as restricted by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information, except for the purposes of treatment, payment, or routine operations (as detailed above), or disclosures made pursuant to your specific authorization.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. PSS generally is not required to abide by your requested restrictions. However, if you pay in full out-of-pocket for a health care item or service, we must comply with your request to restrict the disclosure of health information related to that health care item or service to a health plan for payment or health care operations purposes.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice upon request.

RIGHT TO REVOKE AUTHORIZATION: You have the right to revoke your authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

RIGHT TO RECEIVE CERTAIN NOTICES: You have the right to receive Notice of a Breach. You have the right to receive written notice if we learn of any unauthorized acquisition, use, or disclosure of your PHI that was not otherwise properly secured as required by HIPAA.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS

If you have questions or would like more information regarding any of the rights listed above, please contact PSS's Privacy Officer at the address or telephone number listed below.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED:

You may file a complaint with PSS or with the Secretary of the Department of Health and Human Services. To file a complaint with PSS, please contact:

Pediatric Sleep Specialists Attn:
Privacy/Security Officer
6011 E. Woodmen Road, Suite 115 Colorado
Springs, CO. 80923
719-638-1122

All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

PSS will abide by the terms of the Notice currently in effect. PSS reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. You have the right to review the Notice at any time. PSS will make its Notice, including any revisions, available at PSS and on the PSS website (www.pedsleepcs.com).

I have read and understood the Notice of Health Information Privacy Practices.

Signature of Patient/Legal Guardian: _____ Date: _____

THE EFFECTIVE DATE: The effective date of this Notice is October 15, 2018