



THE CENTER FOR
SLEEP APNEA &
TMJ

An Accredited Dental Sleep Facility

Sleep Apnea & Snoring
TMJ Disorders
Head & Facial Pain

Jamison R. Spencer, DMD, MS
Kevin D. Mangelson, DMD
Nathan J. McArthur, DMD

CRANIOFACIAL PAIN QUESTIONNAIRE

This questionnaire was designed to provide important information regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take time to answer each question as completely and honestly as possible.

PATIENT INFORMATION

MR. MRS. MISS MS. DR. Today's Date: _____

NAME: _____

FIRST MIDDLE INITIAL LAST

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____ MALE FEMALE

CELL PHONE: _____ EMAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DATE OF BIRTH: ____ / ____ / ____ AGE: _____

RESPONSIBLE PARTY: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYER: _____ ADDRESS: _____

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
POLICY HOLDER: _____	POLICY HOLDER: _____
POLICY HOLDER DOB: _____	POLICY HOLDER DOB: _____

Please check box if you are pregnant or think you might be, and let our office know.

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

1. Please **number** your complaints with #1 being the most important, #2 the next important, etc.

2. Then rate your complaints for frequency and intensity.
Frequency: (1-SELDOM, 2-OCCASIONAL, 3-FREQUENT, 4-EVERY DAY)
Intensity: (0 is NO PAIN and 10 is the MOST SEVERE PAIN)

Number	Frequency	Intensity
	1-4	1-10
_____ Back pain	_____	_____
_____ Dizziness	_____	_____
_____ Ear Congestion	_____	_____
_____ Ear Pain	_____	_____
_____ Eye Pain	_____	_____
_____ Facial Pain	_____	_____
_____ Fatigue	_____	_____
_____ Headaches	_____	_____
_____ Jaw Joint Noises	_____	_____
_____ Jaw Locking	_____	_____
_____ Jaw Pain	_____	_____
_____ Limited Mouth Opening	_____	_____

Number	Frequency	Intensity
	1-4	1-10
_____ Muscle Twitching	_____	_____
_____ Neck Pain	_____	_____
_____ Pain when Chewing	_____	_____
_____ Ringing in the Ears	_____	_____
_____ Shoulder Pain	_____	_____
_____ Sinus Congestion	_____	_____
_____ Throat Pain	_____	_____
_____ Visual Disturbances	_____	_____
_____ Other symptoms:	_____	_____

Would you be interested in a consult for Invisalign style braces? Yes No

Patient Name _____ Date _____

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED YOU TO HAVE AN ALLERGIC REACTION:

LIST ANY MEDICATIONS AND DOSAGE CURRENTLY BEING TAKEN (including over the counter medications, vitamins, and supplements) AND THE REASON FOR TAKING THE MEDICATION:

REFERRED BY: _____

 _____ ()
 ADDRESS CITY STATE ZIP PHONE NUMBER

FAMILY DENTIST: _____

 _____ ()
 ADDRESS CITY STATE ZIP PHONE NUMBER

FAMILY PHYSICIAN: _____

 _____ ()
 ADDRESS CITY STATE ZIP PHONE NUMBER

PLEASE LIST ALL TREATMENTS AND HEALTH PROFESSIONALS THAT YOU ARE CURRENTLY SEEING OR HAVE SEEN FOR THIS PROBLEM:

Practitioner: _____ MD/DDS Specialty: _____

 _____ ()
 ADDRESS CITY STATE ZIP PHONE NUMBER

Diagnosis/Treatment: _____ Dates of Treatment: _____

Practitioner: _____ MD/DDS Specialty: _____

 _____ ()
 ADDRESS CITY STATE ZIP PHONE NUMBER

Diagnosis/Treatment: _____ Dates of Treatment: _____

Which of the following have you tried to help your pain/condition? On a scale of 1-5, please rate how effective each was in relieving your symptoms (1-not effective, 2-slightly effective, 3-moderately effective, 4-very effective, 5-most effective)

- | | | | | | |
|---|-----------|--|-----------|------------------------------------|-----------------|
| <input type="checkbox"/> Wearing night guard | 1 2 3 4 5 | <input type="checkbox"/> Massage | 1 2 3 4 5 | Medications (including Advil, etc) | _____ 1 2 3 4 5 |
| <input type="checkbox"/> Stretching exercises | 1 2 3 4 5 | <input type="checkbox"/> Relaxation techniques | 1 2 3 4 5 | _____ | _____ 1 2 3 4 5 |
| <input type="checkbox"/> Ice/moist heat | 1 2 3 4 5 | <input type="checkbox"/> Biofeedback | 1 2 3 4 5 | _____ | _____ 1 2 3 4 5 |
| <input type="checkbox"/> Physical therapy | 1 2 3 4 5 | <input type="checkbox"/> Pain management | 1 2 3 4 5 | <input type="checkbox"/> Other: | _____ 1 2 3 4 5 |

Patient Name _____ Date _____

WHEN DID YOUR CONDITION FIRST OCCUR? _____

WHAT DO YOU BELIEVE IS THE CAUSE OF YOUR PAIN OR CONDITION? _____

	DATE	DESCRIPTION OF INJURY
_____ Motor Vehicle Injury	____/____/____	_____
_____ Worker's Compensation Injury	____/____/____	_____
_____ Accidental Injury	____/____/____	_____
_____ Disease/Injury	____/____/____	_____
_____ Unknown Cause	____/____/____	_____

Describe and give approximate dates of any other trauma to the head, neck or back; any accidents, sports injuries, or other injuries that could have affected the head and neck (even as a child): _____

What other information is important for us to know about your pain or condition? _____

MEDICAL HISTORY (Please specify dates next to conditions marked YES)

- | | | |
|--|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Adenoids removed | <input type="checkbox"/> <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> Tonsils removed | <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> Gout |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> <input type="checkbox"/> Autoimmune disorders | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Heart disorder |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Heart pacemaker |
| <input type="checkbox"/> <input type="checkbox"/> High blood pressure | <input type="checkbox"/> <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> <input type="checkbox"/> Fluid retention | <input type="checkbox"/> <input type="checkbox"/> Heart valve replacement |
| <input type="checkbox"/> <input type="checkbox"/> Bruising easily | <input type="checkbox"/> <input type="checkbox"/> Frequent cough | <input type="checkbox"/> <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Frequent illnesses | <input type="checkbox"/> <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Frequent stressful situations | <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> <input type="checkbox"/> General anesthesia | <input type="checkbox"/> <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> <input type="checkbox"/> Cold hands & feet | <input type="checkbox"/> <input type="checkbox"/> Muscle spasms or cramps | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> <input type="checkbox"/> Immune system disorder | <input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> <input type="checkbox"/> Injury to face | <input type="checkbox"/> <input type="checkbox"/> Needing extra pillows to help breathing at night | <input type="checkbox"/> <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> <input type="checkbox"/> Injury to mouth | <input type="checkbox"/> <input type="checkbox"/> Nervous system irritability | <input type="checkbox"/> <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> <input type="checkbox"/> Injury to neck | <input type="checkbox"/> <input type="checkbox"/> Nervousness | <input type="checkbox"/> <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> <input type="checkbox"/> Injury to teeth | <input type="checkbox"/> <input type="checkbox"/> Neuralgia | <input type="checkbox"/> <input type="checkbox"/> Slow healing sores |
| <input type="checkbox"/> <input type="checkbox"/> Insomnia | <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> <input type="checkbox"/> Intestinal disorders | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Jaw joint surgery | <input type="checkbox"/> <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> <input type="checkbox"/> Swollen, stiff, or painful joints |
| <input type="checkbox"/> <input type="checkbox"/> Kidney problems | <input type="checkbox"/> <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> <input type="checkbox"/> Tendency for frequent colds |
| <input type="checkbox"/> <input type="checkbox"/> Liver disease | <input type="checkbox"/> <input type="checkbox"/> Poor circulation | <input type="checkbox"/> <input type="checkbox"/> Tendency for ear infections |
| <input type="checkbox"/> <input type="checkbox"/> Meniere's disease | <input type="checkbox"/> <input type="checkbox"/> Prior orthodontic treatment | <input type="checkbox"/> <input type="checkbox"/> Tendency for sore throats |
| <input type="checkbox"/> <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> <input type="checkbox"/> Tired muscles |
| <input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Muscle aches | <input type="checkbox"/> <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> Tumors |
| <input type="checkbox"/> <input type="checkbox"/> Muscle shaking (tremors) | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> <input type="checkbox"/> Urinary disorders |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid problems | | <input type="checkbox"/> <input type="checkbox"/> Wisdom teeth extraction |
- Other Medical/Dental History

_____ of BP: _____ Pulse: _____ Height: _____ Weight: _____	FOR OFFICE USE ONLY		
	Date of Initial Screening: ____/____/____ MO	RDD: L: 1-2-3	S&S to: L-R-TMJ-Mass
	<input type="checkbox"/> Aqualizer <input type="checkbox"/> Ice/moist heat <input type="checkbox"/> MRI <input type="checkbox"/> Unlocking	R: 1-2-3	B: NC W ↑MO
	<input type="checkbox"/> PT <input type="checkbox"/> Ibuprofen <input type="checkbox"/> T2 <input type="checkbox"/> Pt Call	Crepitus: L: 1-2-3	L-R-TMJ-Mass
NOTES:	R: 1-2-3	B: NC W ↑MO	
	No joint noises		

Patient Name _____ Date _____

6287 S. Redwood Rd., #101, Taylorsville, UT 84123

(801) 261-9155 | fax (801) 261-9158 | www.SleepAndTMJUtah.com



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**Temporomandibular Joint Dysfunction (TMJ)
Head, and Facial Pain
Financial Policy / Insurance Information**

Your dentist, physician or other health care provider has referred you to our office. It is our goal to treat you with the highest clinical and ethical standards. We have done this for many years in order to warrant the respect of our patients and medical and dental colleagues.

Payment for treatment is obviously necessary; however, we do not like the fact that misunderstandings regarding money issues can often taint an otherwise excellent relationship. To help avoid such a situation, the following has been prepared.

Our doctors are in a unique position as they have D.M.D. (dental) credentials and provide services customarily covered under your major medical benefits. Claims for evaluation and treatment of Temporomandibular Joint Dysfunction (TMD), as well as head and facial pain that are the result of TMD, dental parafunction (grinding or clenching of the teeth), or craniofacial pain are routinely filed under a major medical insurance policy, not a dental plan.

A major medical insurance policy is a legal contract between you or your employer, and an insurance carrier. It establishes the responsibility of the insurance carrier to provide benefit payments to you or your dependents for any treatment that is considered an insured liability under the terms of that contract. Many major medical insurance policies will provide coverage for a portion of your TMJ evaluation and/or treatment. If your policy provides coverage for "articular" or "joint disorders", and does not specifically exclude Temporomandibular Joint Dysfunction and Diseases (or TMD), your policy may provide reimbursement for TMD therapy.

We suggest that you review your medical insurance policy or "benefits booklet" or call your insurance provider so that you may be aware of the specific benefits and limitations of your major medical contract. If prior authorization is required, you are responsible for obtaining that prior to treatment.

You were referred to our office because of our unique expertise in treating pain. Our relationship with you and our ability to treat you are our highest concern. Therefore, we are not willing to let misunderstandings over finances or insurance get in the way of this relationship. We will also never provide a service for you without first explaining the fees for that service.

We are glad to have you as a patient and hope that not only is your painful condition resolved, but that you also have an enjoyable time in our office.

Thank you for your cooperation.

I have read and understand the above financial policy and agree to abide by it.

Signature

(Parent/Guardian Signature if under 18)

Print Name

Date

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The Center for Sleep Apnea & TMJ

Sleep Apnea & Snoring – TMJ Disorders – Head & Facial Pain

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 09/23/2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your medical health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- o Prevent or control disease, injury or disability;
- o Report child abuse or neglect;
- o Report reactions to medications or problems with products or devices;
- o Notify a person of a recall, repair, or replacement of products or devices;
- o Notify a person who may have been exposed to a disease or condition; or
- o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure. If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Kauane Spencer
Telephone: (801) 261-9155 Fax: (801) 261-9155
Address: 6287 South Redwood Rd, #101, Taylorsville, UT 84123
www.sleepandtmjutah.com

The Center for Sleep Apnea & TMJ

Sleep Apnea & Snoring – TMJ Disorders – Head & Facial Pain

Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign This Acknowledgement***

I hereby acknowledge that I may request a copy of this office's

Notice of Privacy Practices if I require one.

Print Name: _____

Signature: _____

Today's Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- € Individual refused to sign
 - € Communications barriers prohibited obtaining the acknowledgement
 - € An emergency situation prevented us from obtaining acknowledgement
 - € Other (Please Specify)
-

The Center for Sleep Apnea & TMJ

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Full Name (Please Print Clearly): _____

Patient Date of Birth (mm/dd/yyyy): _____

SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCAION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT