PACIFIC SLEEP
PROGRAM

CONDITIONS OF REGISTRATION

Medical Consent:

- I consent to the provision of health care services at Pacific Sleep Program and request my health care provider(s) to provide any care they think is necessary and consistent with my instructions.
- I understand this care may include tests, examinations, image captures, and medical treatment. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care.
- I acknowledge that the health care provider(s) treating me may be independent contractors, as well as employees of Pacific Sleep Program.
- I understand if special procedures or operations are needed, my health care provider will discuss this with me.
- I understand that some clinics are teaching institutions and I consent to residents and students being involved with my care. I understand these caregivers are always under the supervision of qualified health care instructors. I understand that I will be informed whenever possible of the resident or student status of specific caregivers.
- As a patient of this practice, I have the right to be treated with professionalism and respect by physicians and staff members. In return, I have a responsibility to treat staff and physicians with professionalism and respect. I understand that non-compliance with this professional behavior agreement may be ground for dismissal from the practice.

HIPAA Acknowledgment:

- I understand that Pacific Sleep Program / Gerald B. Rich M.D. PC. will use and disclose health information about me.
- I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
- I understand and agree that Pacific Sleep Program may use and disclose my health information to:
    - Make decisions about and plan for my care and treatment.

- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.

- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all my health care.

- Perform various office, administrative and business functions that support my physicians /health care providers' efforts to provide me with, arrange and be reimbursed for health care and associated supplies and equipment.

- I understand that I have the right to receive and review a written description of how Pacific Sleep Program will handle health information about me. This written description is known as Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Pacific Sleep Program, and my rights regarding my health information.

- I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

- I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Pacific Sleep Program is not required by law to agree to such requests.

COVID-19:

- The World Health Organization has declared the novel Coronavirus (COVID-19) a worldwide pandemic. Due to its capacity to transmit from person-to-person through respiratory droplets, the government has set recommendations, guidelines, and some prohibitions which Pacific Sleep Program adheres to comply.

- I understand that it is my obligation to protect the staff and other patients from any exposure to the COVID-19 virus as much as possible. As such, I understand that I am required to wear a mask upon entering the clinic and required to wear a mask during the time that I am physically in any portion of the Pacific Sleep Program facilities unless asked by a medical professional to remove the mask for examination or testing purposes. I understand that if I refuse to wear a mask, I will be asked to leave the facility.

- I understand that if I have cough, fever, shortness of breath or other symptoms which may be secondary to the COVID-19 virus, have a family member or close contact with COVID-19, travel to an area of high COVID-19 prevalence or am diagnosed with COVID-19, it is my responsibility to inform the clinic as soon as possible if I plan to attend an in-person visit or perform an in-lab sleep study.

- I understand while Pacific Sleep Program follows state, federal and regulatory rules for masking, cleaning, and distancing to minimize any risk of transmission of COVID-19, Pacific Sleep Program

cannot guarantee that I am not exposed to the virus during my physical presence in their facilities. As such, I hereby agree to indemnify and hold harmless and do hereby release Pacific Sleep Program from any claims, actions or causes of action for any personal injury because of COVID-19 infection.

Telemedicine services:

I hereby consent to using live telemedicine services provided by Pacific Sleep Program. I understand that telemedicine services are conducted through an interactive audio and video connection which allows my provider to consult with me about my medical condition. I understand that these services may involve the communication of my health information, both orally and visually, to my provider.

I further understand the following with respect to Pacific Sleep Program's telemedicine services:

- No data or health information will be recorded, stored, or archived from the audio/video portion of these services.
- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I understand that the information disclosed to me during my telemedicine session is except as per mandatory and permissive exceptions to confidentiality in the State of Oregon.
- Risks and consequences from use of these services may include but are not limited to, the possibility that the transmission of my health information could be intercepted or accessed by unauthorized persons and the inability to perform a physical exam through telemedicine.

General Consent for sleep studies and PAP (positive airway pressure) application:

For sleep studies, (either at home or in lab) and PAP application, the most likely and most serious risks of the procedure include, but are not limited to:

- Contact dermatitis
- Adverse reactions to adhesives
- Aerophagia
- Eustachian tube dysfunction
- Pneumothorax
- Anaphylactic reactions (rare)

I am aware that there may be other risks or complications not discussed that may occur. I also understand that during the proposed procedure, unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required because of this procedure.

Sleep testing and the use of sedative-hypnotics:

If I take a sleep aid before or during a sleep study, I am aware that sedatives such as diphenhydramine (Benadryl), doxylamine (Unisom), trazodone, Ambien (zolpidem), Sonata (zaleplon) and other sleep aids may impair my thinking and reaction time. I understand that I may feel drowsy in the morning after taking a sleep aid.

I understand that Pacific Sleep Program strongly recommends that I wait at least 7 hours or until I am fully awake before I do any type of activity that requires me to be awake and alert. If I am unable to safely operate a motor vehicle, I understand that I must have a ride home available in the morning or, if day staffing is available the next day, I will remain in the clinic until I am able to safely operate a motor vehicle or will contact someone to drive me home.

If I decide to terminate my study, I acknowledge that I am refusing at my own insistence and without the authority of and against the advice of the facility, requesting to leave against medical advice and I hereby release Pacific Sleep Program from any responsibility for all consequences which may result from the use of a sleep aid during the study or from leaving against medical advice.

Prescription Policy:

Please contact your pharmacy for prescription refills. Medication refill request may take up to 5-7 business days to process. Prescriptions will be handled Monday through Thursday, 8:00 AM-4:30 PM. There will be no refills after hours or on the weekends so please plan accordingly.

Pacific Sleep Program will only authorize refills on medications prescribed by Pacific Sleep Program providers. Medications prescribed by other providers will not be refilled by Pacific Sleep Program.

Pacific Sleep Program will notify you if the prescription has been denied or there is a need for a follow up visit prior to refilling your medication. Keep in mind that controlled substances require signed prescriptions by law and cannot be refilled without an office visit.

Controlled Substance Agreement:

Controlled substances are those that are closely controlled by local, state, and federal government.

I understand that the long-term use of such substances as sedatives (Ambien, Lunesta), benzodiazepines (Xanax, Klonopin), and stimulants (Adderall, Ritalin) is controversial because it is not certain whether they help patients over the long-term. Patients who are prescribed these drugs have some risk of developing an addictive disorder or suffering a relapse of a prior addiction. The extent of this risk is not certain.

I understand that dependence is not the same as addiction. Many people who take controlled substances daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms can include moodiness, ache, and pains, sweating, diarrhea, abdominal pain and even seizures.

I understand that addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use, and craving, and continued use despite harm or risk to the person.

I understand that if I am prescribed controlled substances, I should not increase the dose or stop the medication unless asked to do so by their provider or their covering associate.

I understand that I must follow through on appointments and other non-medication recommendations. These may include counseling and other mental health practices and use of positive airway pressure. Consistent failure to keep these appointments and therapies may result in the stopping of the controlled substance medications or possibly discharge from the practice. **No refills will be given during holidays, at night or on weekends.**

I understand that early refills will not be given unless approved by my provider.

I understand that I will not tamper with or change a written prescription and understand that is a felony to do so.

I understand I will not share, exchange, or sell my controlled substance medications, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to authorities for investigation.

I understand that I take another person's-controlled substance (prescribed either by Pacific Sleep Program or another providers office), I will be discharged from Pacific Sleep Program and may be reported to the authorities for investigation.

I understand I will not use illegal/street drugs when using controlled substance prescribed by Pacific Sleep Program. Patient will not use other controlled substance medications for sleep unless prescribed by the provider.

I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or is the results are unsatisfactory, I may forfeit the right to continue receiving the medication and possibly be discharged from the practice.

If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

I recognize that controlled substances by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

It is my responsibility to keep my medication safe. If controlled substance medications are lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at

individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

Financial Agreement:

As a courtesy to you, our office will bill your insurance company on your behalf for services rendered, provided complete and accurate information is provided at the time of each visit.

- I understand full payment is required at the time of service for all co-payments, deductibles, and services or products not covered by or not billable to my insurance company.
- I understand I am responsible if insurance payment is not received after 30 days, the balance in full becomes my responsibility. Accounts are payable in full at time of billing.
- I understand I will be charged a fee of **$75.00 for a missed provider appointment, whether the appointment is conducted in the office or telemedicine** or if I cancel my appointment in less than 1 business day of the scheduled appointment.
- I understand I will be charged a fee of **$250.00 for a missed sleep study appointment** or if I cancel in less than 2 business days of the scheduled sleep lab appointment.
- **I understand all late cancellation fees and missed appointment fees are NOT payable by my insurance company and will be billed directly to me.**
- **I understand if I have up to 2 late cancellations or no-shows of office appointments or 1 late cancellation/no-show of a sleep study, I may be discharged from the practice.**
- I understand I will be charged a **$35.00 service charge on all returned checks.**
- I understand if my account is directed to a collection agency for non-payment of services, I may be discharged from the practice.
- I understand if my insurance requires me to have a referral for services provided by Pacific Sleep Program, it is my responsibility to obtain the referral.
- I understand that if my insurance changes, I am responsible for notifying Pacific Sleep Program immediately prior to any further visits, sleep testing or DME dispensing and that if I do not, I am fully responsible for any charges which may not be covered by my insurance.

Financial Certification:

I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing this form.

By signing below, I (Patient or Authorized Consenter) hereby acknowledge I have read and fully understand the above information. I have asked questions about anything not clear to me and am satisfied with the answers I have received. I understand that I may revoke my consent or authorization at any time except to the extent that action has been taken in reliance on such consent or authorization.

_____	_____	_____
Patient or Legal Representative	Relationship	Date