Robert V. Sibilia, M.D.
Specializing in Sleep Medicine & Pulmonology
324 E. Milltown Rd., Suite A
Wooster, OH 44691
Phone (330) 345-2459 Fax (330) 345-3756

Notice of Consultation Appointment

Dear _____,

You have been scheduled for a consultation appointment in our office on

_____, _____ at _____.

If this time does not work for you, please call us to reschedule. Please keep in mind that if you do not give us a 24-hour advance notice or fail to show for your appointment you will be charged a fee of $25.00.

We ask that you refrain from wearing perfume or cologne as the office does see many patients with breathing difficulties and this could cause serious reaction. Please plan to spend about 90 minutes in our office.

Bring the following to your appointment:

- Driver's license
- Insurance card(s) and copay - OR *payment in full* if self-pay
- List of all medications you are currently taking
- If you are a pulmonary patient and have had recent chest x-rays or CT scans at a facility other than Aultman-Orrville, Joel Pomerene, or Wooster Community Hospitals please bring the CD of your studies from the other facility to your appointment.
- If you are a sleep patient and have had recent sleep studies, please bring any results from those studies to your appointment.

Thank you!

Dr. Robert V. Sibilia & Staff

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Patient Registration Form

Patient Name_____ Date _____

Street Address_____ Home Phone _____

City/State/Zip _____ Cell Phone _____

Employer _____ Work Phone _____

Date of Birth _____ Sex: M / F Marital Status: Married / Single / Divorced / Widowed

Social Security # _____ Primary Care Physician _____

IF YOUR INSURANCE COVERAGE IS THROUGH ANOTHER PERSON (e.g., Spouse, Parent, Guardian, etc.), **PLEASE PROVIDE ALL INFORMATION BELOW ON THAT PERSON**. THIS IS REQUIRED TO FILE CLAIMS ON YOUR BEHALF WITH THE INSURANCE COMPANY.

Insured Name _____ Insured Date of Birth _____

Insured Social Security # _____ Insured Employer _____

Consent to Treat and Payment Policy

I consent to all treatment necessary for the care of the above named patient.

I authorize the release of all medical records to the referring physician, family physician, and to my insurance company, if applicable. I further authorize and request that all insurance payments be made directly to Dr. Robert Sibilia.

I understand that if I fail to show for my office appointment or cancel my office appointment with less than 24 hours notice, I will be charged a $25.00 fee. If I fail to show for my sleep study or cancel my sleep study with less than 48 hours notice, I will be charged a $75.00 fee.

I understand that my insurance company requires co-payments to be collected at the time of service, and if not paid at that time, will be subject to a $5.00 additional fee for billing and mailing costs.

I agree that in order for Robert V. Sibilia, MD, Inc. to collect any amounts I may owe for treatment, I may be contacted by telephone at any and/or all telephone numbers associated with my account, including wireless telephone numbers, which may result in charges to me from my wireless carrier.

In the event that my account must be turned over to a Collection Agency for payment, I also agree that the Collection Agency may contact me in all of the ways listed above, and that methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. I agree that if my account is placed with a Collection Agency and legal action is initiated, I will be responsible for any amount due, including but not limited to interest, fees, charges, and/or expenses incidental to the principal obligation prior to a judgment being rendered against me.

I understand that I, the patient, am responsible for all financial obligations of my health care services. I acknowledge that if I have insurance, I am still financially responsible for the amounts not covered by my insurance carrier; or, if uninsured, that I am responsible for the full cost of my treatment.

Signature _____ Date _____

(Patient Signature, if over 18; Signature of Parent/Guardian if patient is a minor) *Office Use Only: Rec'd by* _____

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PATIENT REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternate means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding our communication of Protected Health Information to you:

____ You may call my home/cell telephone number with confidential information.

____ Please DO NOT call my home/cell telephone number with confidential information.

____ Please DO NOT call my work telephone number with confidential information.

____ You may leave messages on my telephone answering machine.

____ Please DO NOT leave messages on my telephone answering machine.

____ Please DO NOT send confidential communications to my home address.

____ Please DO NOT send confidential communications to my work address.

____ Please use this address to send confidential communications: _____

Please list anyone you wish to be able to receive your Protected Health Information if necessary:

Spouse _____ Other Relative _____

Power of Attorney _____ Other _____

_____ _____

Print Name **Signature**

Date: _____

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT FORM

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment and health care operations, you must acknowledge that you have received a copy of our NOTICE OF PRIVACY PRACTICES informing you how our office may use and disclose your PROTECTED HEALTH INFORMATION.

You should carefully read our NOTICE OF PRIVACY PRACTICES to understand how we take steps to protect the privacy and confidentiality of your PROTECTED HEALTH INFORMATION. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include:

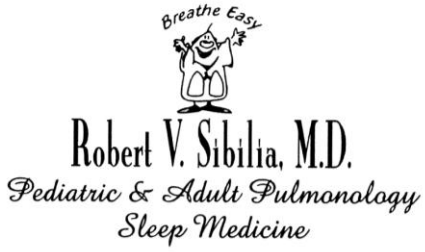
1) The right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment, or health care operations
2) The right to receive confidential communications of your Protected Health Information, if applicable
3) The right to inspect and copy your Protected Health Information
4) The right to amend your Protected Health Information
5) The right to receive an accounting of the disclosures of your Protected Health Information

By signing this form, you acknowledge that you have received a copy of our NOTICE OF PRIVACY PRACTICES concerning the use and disclosure of your PROTECTED HEALTH INFORMATION.

Name of Patient/Legal Representative _____

Signature _____

Date: _____



Robert V. Sibilia, MD, Inc
and **Advanced Sleep Care**
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected Health Information (PHI) about you is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present, or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization at any time, in writing, except to the extent that our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication. This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone) and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by Ohio Department of Health guidelines.

You have the right to request a restriction of your PHI. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you or someone on your behalf has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information. This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability. This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice. You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment. We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment. Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare

services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, auditing functions, and patient safety activities.

Health Information Organization. The practice may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures. We are also permitted to use or disclose your PHI without your written authorization: as required by law; for public health activities; for health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; for research purposes; in legal proceedings; for law enforcement purposes; to coroners and funeral directors; in cases of organ donation; in cases of criminal activity; for military activity; for national security; for worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

Robert V. Sibilia, MD
324 E Milltown Rd, Suite A
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We will not retaliate against you for filing a complaint.

Effective Date

This Notice is effective on or after September 23, 2013.