Dear _____

You have an appointment with *Dr. Daniel Root* on _____ at _____am / pm. Thank you for considering Oregon Sleep Associates for the evaluation and treatment of your sleep concerns. In order to facilitate your care, we would like you to take a few minutes and carefully answer the questions in the enclosed forms to help us serve you better. Please remember to bring all insurance cards, photo ID, along with your co-pay. At the time of your consultation appointment, our staff will be taking a picture of you to be used in our electronic medical records system.

If you have not thoroughly completed your paperwork prior to your appointment, we will need you to arrive 20 minutes early for registration. Please do not bring children, as we do not provide childcare and they may not accompany you into the exam room. If needed, please bring your own language interpreter, we do not provide this service. If you require special assistance please make appropriate arrangements before coming to your appointment. If for any reason you need to reschedule your appointment, please call our office at least 24 hours in advance. For further questions please call (503) 288-5201.

We hope that you have a satisfying experience here and that all of your sleep health needs are met. We appreciate any feedback that you may have regarding your experience.

Thank you,

Oregon Sleep Associates Team

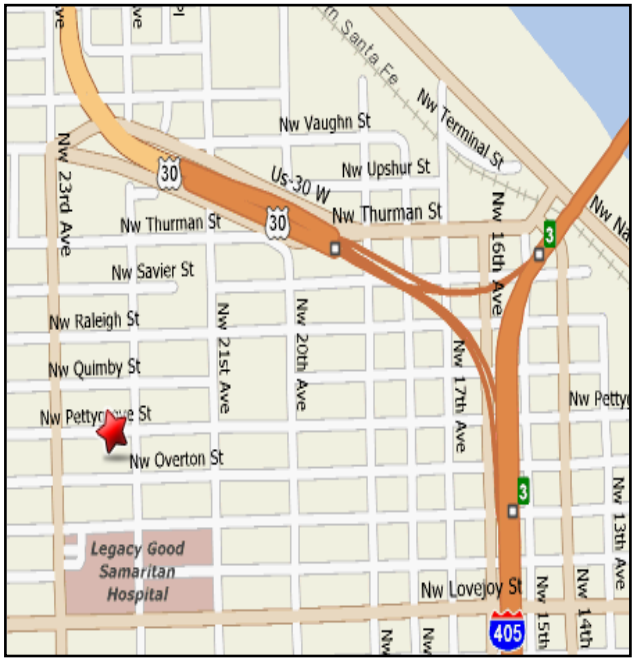
2228 NW Pettygrove Suite 150 • Portland, OR 97210 • Phone: 503.288.5201 • Fax: 503.288.0151

Directions

From *Gresham*:
Take I-84 West to I-5 North
Take the I-405 South/Hwy 30 exit
Cross Fremont Bridge follow to Vaughn St Exit
Turn left onto NW 23rd Ave
Turn left onto NW Pettygrove St

From *Vancouver*:
Take I-5 South towards Portland
Merge onto I-405/US-30 W exit 302B
Merge onto US-30 W exit 3 to NW Ind. Area
Merge onto US-30 W via the Vaughn St exit
Turn left at NW 23rd Ave
Turn left at NW Pettygrove St

From *Beaverton/Salem*:
Take the I-405 toward Hwy 30
Take Exit #3 toward Hwy 30
Take ramp right toward Vaughn.
Turn Left onto NW 23rd Ave
Turn Left onto NW Pettygrove St



Parking available in our underground garage.
Pettygrove Medical Center

Oregon Sleep Associates
2228 NW Pettygrove St, Suite 150
Portland, OR 97210
503-288-5201

Patient Information

Name: _____ DOB: ____/____/____
Last First MI

Address: _____
Street City State Zip

Social Security # ____-____-____ Home Phone: (____) _____ Cell Phone: (____) _____

Gender: ☐ M / ☐ F Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Other

Race:

☐ American Indian or Alaskan Native ☐ Asian

☐ Black/African American ☐ Caucasian/White

☐ Pacific Islander ☐ Decline/Refuse

☐ Other: _____

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

☐ Decline/Refuse

Language:

☐ English ☐ Spanish ☐ Other: _____

Employer: _____ Work Phone: (____) _____

Employer's Address: _____
Street City State Zip

Preferred Pharmacy: _____ Address: _____

Responsible Party (If different from self)

Name: _____ DOB: ____/____/____
Last First MI

Relationship to patient: _____ SSN: ____-____-____ Sex: M / F

Address: _____
Street City State Zip

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Employer's Address: _____
Street City State Zip

Emergency Contact

Name: _____ Contact Phone: _____

Insurance Information

Primary Insurance: _____ Policy # _____ Group ID # _____

Insurance Address: _____ Phone No.: _____

Policy Holder's Name: _____ DOB: ____/____/____ Relationship: _____

Employer: _____ Work Number: _____

Secondary Insurance: _____ Policy # _____ Group ID # _____

Insurance Address: _____ Phone No.: _____

Policy Holder's Name: _____ DOB: ____/____/____ Relationship: _____

Employer: _____ Work Number: _____

Referring Provider: _____ **Primary Care Provider:** _____

Have you received heath care under another name? **Y / N**
If yes, name used: _____

AUTHORIZATION FOR INSURANCE BENEFITAUTHORIZATION

IN CONSIDERATION FOR SERVICES RENDERED, I HEREBY AUTHORIZE DIRECT PAYMENT TO THE PHYSICIAN OR SUPPLIER; I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. IN ADDITION, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signature: _____ Date: _____

Release of verbal Medical Information:

I. Permission to Verbally Discuss PHI with Family Members / Caregivers:
I hereby authorize medical providers and personnel of Oregon Sleep Associates to discuss my protected health information with the following person(s):

Name/Phone number:_____ Relationship:_____

Name/Phone number:_____ Relationship:_____

Name/Phone number:_____ Relationship:_____

-or- ☐ **I decline.** Please do not discuss my care with anyone other than as allowed by HIPAA regulations.

II. Permission to Leave a Detailed Message:
I herby authorize the medical providers and personnel of Oregon Sleep Associates to leave a detailed message at the following **phone number:**_____

Appointment reminders only at phone: _____

Email: _____

-or- ☐ **I decline.** Please do not leave me detailed messages.

_____ _____
Signature of Patient/Personal Representative **Name of Patient/Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**

OSA
Oregon Sleep Associates

QUESTIONNAIRE FOR SLEEP PATIENTS

PLEASE FILL THIS OUT AFTER DISCUSSING IT WITH YOUR BED PARTNER OR ROOMMATE.

NAME :_____ DATE:_____
AGE: _____

Where did you hear about us? _____

SLEEP PROBLEM

1. Briefly describe your main problem, how long you have had it and how it affects your day-to-day life.

2. Have you ever had a sleep study before for this problem? ☐Yes ☐No
   If so, when, where and what were the results? _____

3. Please check all the following that apply to your sleep problem:
   - ☐ Difficulty falling asleep
   - ☐ Waking up during the night
   - ☐ Difficulty falling back to sleep after waking in the night
   - ☐ Waking up early in the morning (before expected time)
   - ☐ Difficulty awakening in the morning
   - ☐ Feeling like the quality of your sleep wasn't very good
   - ☐ Sleepiness during the day
   - ☐ Daytime fatigue even when you're not sleepy

4. Can you identify anything that either makes your nighttime sleep problem better or worse? ☐Yes ☐No
   If so, please describe.

5. Can you identify anything that makes your daytime impairment better or worse? ☐Yes ☐No
   If so, please describe.

6. How upsetting is this problem to you?
   ☐ mildly upsetting ☐ moderately severe ☐ severe ☐ totally incapacitating

7. How much do you want help with your problem?
   ☐ a great deal ☐ moderate amount ☐ could do without it

8. Why do **you** think you have this particular sleep/wake problem?

SLEEP ONSET

1. What time do you usually go to bed on weekdays? _____ on weekends? _____

2. On average, how long does it usually take you to fall asleep after lights are turned off? _____
   If more than 30 minutes, how many time per week does this occur? _____

3. Do you consider yourself a morning person ("early bird") or an evening person ("night owl")? ☐Yes ☐No

4. During the past several years, have you taken any medications (prescribed or over-the-counter) or tried any therapies (e.g., meditation, relaxation, etc.) to help you sleep? ☐Yes ☐No If so, please describe effect.

TREATMENT	EFFECT
_____	_____
_____	_____
_____	_____
_____	_____

5. Do you have any routine before bedtime? ☐Yes ☐No If so, please describe.

	Yes/No	How often?	How long?	In the bedroom?
Read				
Watch TV				
Other media (computer, phone)				

6. Check all of the following that may keep you from falling asleep:
   - ☐ Thoughts racing through your mind
   - ☐ Worrying about things
   - ☐ Feeling sad or depressed
   - ☐ Feeling afraid of going to sleep
   - ☐ Experience vivid or frightening dream-like scenes (hallucinations) even though you know that you are awake
   - ☐ Feel unable to move (paralyzed)
   - ☐ Parts of your body startle or jerk

7. Do you experience persistent and uncomfortable feelings in your legs while sitting or lying down? ☐Yes ☐No
   If yes, please answer the following questions:
   a. Is there a persistent need or urge to move your legs? ☐Yes ☐No
   b. Are these uncomfortable feelings or urge to move your legs worse in the evening or night compared with the morning? ☐Yes ☐No
   c. Do they disappear or improve when you are active or moving around? ☐Yes ☐No
   d. How often do they disturb your ability to fall asleep? ☐Every night ☐> 1-2 times a week ☐ Rarely ☐ Never

8. Do you suffer from chronic pain? ☐Yes ☐No If yes, please answer the following questions:
   a. What diagnosis (either confirmed or provisional) have you been given by a professional regarding your chronic pain? _____
   b. Is falling asleep impaired by pain? ☐Yes ☐No
   c. Are you waking up at night due to pain? ☐Yes ☐No
   d. Does your pain improve with sleep? ☐Yes ☐No

DURING THE NIGHT

1. How many total hours of sleep do you usually get at night? _____

2. How much sleep do you think you need to feel refreshed? _____

3. Do you sleep better in places other than your bed or bedroom? ☐Yes ☐No

4. What body positions do you sleep in? ☐Back ☐Sides ☐Stomach ☐Upright or head elevated

5. Do you usually awaken during the night? ☐Yes ☐No
   If so, how many times? _____ How long are you usually awake?_____
   What keeps you awake?_____

6. If you do awaken during the night, is it:
   ☐ Soon after falling asleep ☐ Middle of the night ☐ Early morning

7. Please rate the following questions about your sleep in the last 3 months:

	Never	Sometimes	Always
Sleep with someone else in your bed or room			
Provide assistance to someone during the night			
Snore			
Snort or Awaken from your own snoring			
Someone is bothered by your snoring			
Told that you stop breathing			
Wake up gasping for air			
Wake up choking			
Wake up coughing			
Sweat excessively			
Move excessively (toss and turn)			
Have nasal congestion or stuffiness			
Awaken with dry mouth			
Awaken with headache in the middle of the night			
Awaken with palpitations			
Awaken with sour taste or heartburn			
Awaken with an urgent desire to urinate If so, how many times? _____			
Wet your bed as an adult			
Have your sleep disrupted by pain			
Have your sleep disrupted by light, noise, heat, cold or bed partner			
Grind your teeth			
Have nights filled with intense vivid dreams			
Begin dreaming immediately after falling asleep			
Have nightmares or disturbing dreams			
Wake up because of a dream			
Have difficulty falling back asleep after waking from a dream			
Waken from sleep screaming and/or confused			
"Act out" your dreams			
Accidentally hurt yourself or your bed partner			
Talk, walk or eat			
Legs twitch or kick			
Have convulsions or seizures			

AWAKENING IN THE MORNING

1. Time of usual final awakening on weekdays _____ on weekends _____

2. Time you leave your bed on a typical morning _____

3. Time it takes to feel fully awake after getting out of bed _____ OR ☐Never feel fully awake

4. Please rate how often you:

	Never	Sometimes	Always
Notice that you are unusually difficult to wake up in the morning			
Depend on an alarm to wake up			
Wake up with a morning headache			
Feel unable to move (paralyzed) when waking up			

DAYTIME FUNCTIONING

1. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

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…….._____
Watching TV …….._____
Sitting, inactive in a public place (e.g., a theater or a meeting) ……_____
As a passenger in a car for an hour without a break …….._____
Lying down to rest in the afternoon when circumstances permit …….._____
Sitting and talking to someone ……..._____
Sitting quietly after lunch without alcohol ……_____
In a car, while stopped for a few minutes in traffic ……_____

2. Do you take daytime naps? ☐Yes ☐No If yes, how often and for how long? _____
Do you feel refreshed afterwards? ☐Yes ☐No If yes, for how long? _____

3. Have you recently:

		How Often or How Long?
Felt sleepy while driving	☐Yes ☐No	
Had accidents (work, auto) related to sleepiness	☐Yes ☐No	
Had "near-accidents" related to sleepiness	☐Yes ☐No	
Felt fatigue (exhaustion, tiredness) even when you are not sleepy	☐Yes ☐No	
Become increasingly irritable or short-tempered	☐Yes ☐No	
Found that your mind is not working as quickly or effectively as it used to	☐Yes ☐No	
Had decreased desire for sexual activity	☐Yes ☐No	
Felt depressed or anxious	☐Yes ☐No	

4. Have you ever had episodes of sudden muscular weakness (eg, buckling of your knees) when laughing, angry or emotional? ☐Yes ☐No

5. How much of the following do you have?

	IN A USUAL 24 HOUR PERIOD:	WITHIN 8 HOURS OF GOING TO SLEEP:
Coffee	_____cups	_____cups
Caffeinated Tea	_____cups	_____cups
Soda/Pop	_____bottles/cans	_____bottles/cans
Other caffeinated drinks	_____	_____
Stimulant medications	_____	_____

6. How many alcoholic drinks do you have during a usual 24 hour period?

	WEEKDAYS	WEEKENDS	WITHIN 2 HOURS OF GOING TO SLEEP:
Bottles (cans) of beer	_____	_____	_____
Glasses of wine	_____	_____	_____
Shots of liquor	_____	_____	_____

7. Do you use or have you used tobacco products? ☐Yes ☐No If yes, how much and for how long? _____
If quit, when? _____

8. Do you use or have you used other illicit drugs? ☐Yes ☐No If yes, which ones and for how long? _____

GENERAL HEALTH

1. Please check the following you have, or have had, problems with:

General
___ Weight loss
___ Weight gain
___ Chronic pain

Eyes
___ Eye disease

Ears/Nose/Throat/Neck
___ Hearing loss
___ Nasal allergies
___ Runny nose
___ Post-nasal drip
___ Nose bleeds
___ Sinusitis
___ Nasal polyps
___ Deviated septum
___ Jaw pain or clicking
___ Dentures
___ Orthodontics (braces)
___ Over-bite
___ Under-bite
___ Jaw surgery
___ Tonsillectomy
___ Adenoidectomy
___ Sinus surgery
___ Neck surgery

Cardiovascular
___ High blood pressure
___ High cholesterol
___ Heart disease
___ Heart failure
___ Abnormal heart rhythm
___ Angina
___ Swelling of the ankles
___ Heart surgery
___ Angioplasty
___ Pacemaker
___ Murmurs

Respiratory
___ Hoarseness
___ Chronic cough
___ Shortness of breath
___ Chest pain or tightness
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Emphysema

Gastrointestinal
___ Difficulty swallowing
___ Heartburn
___ Ulcer
___ Liver disease

Urologic
___ Kidney disease
___ Prostate problems
___ Loss of urine involuntarily

Skin/Musculoskeletal
___ Skin disease
___ Rash
___ Muscle or joint pain
___ Scoliosis
___ Arthritis
___ Fibromyalgia

Endocrine
___ Diabetes
___ Heat/cold intolerance
___ Cold hands/feet
___ Impotence
___ Thyroid imbalance
___ Menstrual disorders
___ Postmenopausal

Hematology/Oncology
___ Anemia
___ Cancer: type _____

Allergic/Immunologic
___ HIV infection or AIDS

Psychiatric
___ Depression
___ Anxiety/Panic attacks
___ Bipolar disorder
___ PTSD
___ ADD/ADHD
___ Poor concentration
___ Mood swings
___ Suicidal thoughts
___ Mental, physical or sexual abuse
___ Excessive energy
___ Claustrophobia

Neurologic
___ Chronic headaches
___ Numbness or tingling
___ Memory loss
___ Tremor
___ Loss of balance
___ Head injury
___ Meningitis
___ Seizures
___ Epilepsy
___ Stroke

2. Are there any other illnesses you have had that are not mentioned on previous page?

3. Please list hospital admissions (including medical and psychiatric) and surgical operations:

YEAR	REASON FOR ADMISSION OR SURGERY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Please list all current medications (including non-prescription medications):

NAME	DOSAGE PER DAY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5. Do you have allergies to medications? ☐Yes ☐No If yes, please explain adverse reaction.

6. Does anyone in your family have any of the following:

☐ Snoring	☐ Insomnia	☐ Hypertension or Heart disease
☐ Sleep apnea		☐ Stroke
☐ Restless Legs Syndrome	☐ Narcolepsy	☐ Diabetes

7. Are you employed outside your home? ☐Yes ☐No If yes, what is your present occupation? _____
   Are you a shift worker? ☐Yes ☐No
   If yes, what shift do you usually work? ☐Day shift ☐Night shift ☐Rotating shift

8. With whom are you now living? (spouse, partner, children, parents, etc., please list first names and ages)

9. What is/was your body weight:
   - Now: _____ pounds
   - 6 months ago: _____ pounds
   - 2 years ago: _____ pounds
   - At age 20: _____ pounds
   - At your heaviest: _____ pounds

10. Do you do any physical exercise? ☐Yes ☐No
    If yes, what do you do, when, and how often?
    _____
    _____

Thank you so much for taking the time to fill out this questionnaire.
It will aid us greatly in helping you with your sleep problems.

OSA
Oregon Sleep Associates

Spouse or Roommate Questionnaire

Name of patient: _____ Date: _____

Check any of the following you have observed the patient doing:

While Asleep	While Awake
☐Loud Snoring	☐Depression
☐Light Snoring	☐Change in personality
☐Twitching of Legs or Feet	☐Loss of intellectual function
☐Pauses in breathing	☐Excessive daytime sleepiness
☐Sleep talking	☐Weight gain
☐Not breathing	☐Fatigue
☐Sitting up in bed not awake	☐Morning headaches
☐Kicking of the legs	☐Irritability
☐Struggling to breath while asleep	☐Trouble driving
☐Insomnia	☐Traffic accidents

How long have you been aware of the sleep behaviors that you checked above?

_____

_____

_____

Describe the sleep behaviors checked above in more detail. Include the type of activity, the time of night in which it occurs, frequency during the night and whether it occurs every night.

_____

_____

_____

If you have described loud snoring, do you remember hearing short pauses in the snoring or occasional loud snorts? _____

Financial Policy

In order to assure that you receive every benefit to which you are entitled, we require your current insurance card, as well as any required referral or authorization, prior to each visit. If you have any questions regarding your insurance coverage prior to your visit, please call your insurance company and our office at **(503) 288-5201**.

You are required to pay any co-payment amount at the time of service. If you do not pay your co-pay, you may be assessed a fee of $25.00 per co-pay not paid. Additionally, you are responsible for the timely payment of your account balance for co-insurance, deductible and other items your insurance will not pay.

For your convenience we accept cash, checks, Visa and MasterCard. All patient balances are due within 30 days of our statement date, unless prior arrangements have been made with our billing department. A list of our fees is available upon request.

Insurance is a contract between you and your insurance company. We are not a party of this contract. We will bill your insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. **Failure to provide complete insurance information will result in patient responsibility for the entire bill**. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Any amount unpaid by your insurance company becomes your responsibility.

Our office staff is always willing and available to discuss billing matters with you at any time. We know that you will agree that your clear understanding of our financial policy is important to our professional relationship. You may call the **Billing office** at (**503) 288-5201**.

As a patient, you are responsible to contact our office to re-schedule or cancel an office appointment and/or sleep lab appointment. Failure to cancel appointment on short notice or no show for appointment will result in a fee being assessed, per incident, on your patient account that will not be billed to insurance.

I have read, understand and agree to the terms of the above Financial Policy.

Patient Signature _____ Date _____

Effective Date: 7/25/2011

Oregon Sleep Associates
Notice of Privacy Practices
September 23rd, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care, and your family. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Continue Next Page

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at *Oregon Sleep Associates, LLC*. If you have questions and would like additional information, you may contact us at (503) 288 – 5201.

_____ _____

Patient Name please print Date

_____

Patient signature / Parent or Guardian