Ocean Sleep Medicine
11 Mareblu, Ste. 200, Aliso Viejo, CA 92656
Phone: (949)446-8990 Fax: (949) 446-8535

PATIENT COMMUNICATION CONSENT

Consent for Communication Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. **Ocean Sleep Medicine** respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. **Ocean Sleep Medicine** will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

I authorize **Ocean Sleep Medicine** to contact me by telephone with medical information pertaining to my care. If I am unavailable, this authorization gives **Ocean Sleep Medicine** to leave this information either on my answering machine or with a member of my household.

Authorized Individuals
The following people are authorized to discuss my personal health information and coordinate with **Ocean Sleep Medicine** for evaluation and treatment, including follow up appointments, telephone communication, scheduling appointments and may be contacted in case of an emergency. (Authorized caregivers are not able to request and transfer records)

Patient Name _____ Relationship_____Phone Number _____

Responsible Party:_____Relationship_____Phone Number _____

☐ I do not consent to any voicemail, email or texting communication.

☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):

☐ Email:_____ ☐ Text _____ ☐ Voicemail _____
(EMAIL ADDRESS) *(TEXT NUMBER)* *(VOICEMAIL NUMBER)*

☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):

☐ Email:_____ ☐ Text _____ ☐ Voicemail _____
(EMAIL ADDRESS) *(TEXT NUMBER)* *(VOICEMAIL NUMBER)*

I UNDERSTAND AND AGREE TO THE ABOVE_____ Date:_____
Signature of Patient or Authorized Patient Representative

Relationship to patient: *Self* ☐ *Spouse* ☐ *Parent* ☐ *Guardian* ☐

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CANCELLED/MISSED APPOINTMENTS

Appointments are scheduled according to each patient's needs and the availability of the physician. The time of your appointment is reserved for you. All cancellations and/or rescheduling of appointments MUST be done at least 48 hours in advance. Patients, who cancel the day of an appointment or do not show, will incur a $50.00 cancellation/no show fee. This fee cannot be billed to your insurance company and is payable by the patient or their guardian. We will require a payment over the phone if you have had a no show or late cancel BEFORE we can schedule your next appointment. Please note that if there are three consecutive cancellations, you will no longer be eligible for a consult at our office.

I UNDERSTAND AND AGREE TO THE ABOVE_____ Date:_____

Signature of Patient or Authorized Patient Representative

Relationship to patient: *Self* ☐ *Spouse* ☐ *Parent* ☐ *Guardian* ☐

MEDICATION REFILL POLICY

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
- Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). The urgent care staff will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.
- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3 to 6 months.
- If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.
- New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

I UNDERSTAND AND AGREE TO THE ABOVE_____ Date:_____

Signature of Patient or Authorized Patient Representative

Relationship to patient: *Self* ☐ *Spouse* ☐ *Parent* ☐ *Guardian* ☐

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____ _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize OCEAN SLEEP MEDICINE and any of its employees to use or disclose my Patient Health information to the following person(s) or entities(s): (This includes your referring physician, primary care, dentist etc.)

1. _____
2. _____
3. _____

Release the following records – check (√) :

- ☐ Consultation note
- ☐ Follow up notes
- ☐ All clinic notes
- ☐ PSG Report
- ☐ PAP Titration Report
- ☐ MSLT / MWT Report
- ☐ All sleep study reports
- ☐ All of the above

I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of other copies.

- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to Ocean Sleep Medicine receiving a written notice of withdrawal.
- I hereby release Ocean Sleep Medicine and its officers, directors, agents and employees from any and all liabilities, responsibilities, damages, losses and claims which might arise from the release of the information authorized above.
- In furtherance of the authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.

Effective dates for this authorization: ____/ ____/ ____ through ____/ ____/ ____ or ☐ until further notice is given. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature, unless otherwise specified. This authorization will expire at the end of the above period.

I understand I have the right to:

• I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patients Authorized Representative *Date*

_____ _____
Signature of Ocean Sleep Medicine Representative *Date*