4 BETTER SLEEP
CENTERS

WHAT YOU NEED TO KNOW… ABOUT YOUR SLEEP STUDY

- **PLEASE KEEP YOUR APPOINTMENT:**
  A room has been reserved for you. As a courtesy, if you are unable to keep your reservation **PLEASE CALL US @ (214) 466-7222** so we may attempt to fill that opening. We must hear from you by noon the day before your study – **if you do not confirm the appointment or cancel after that time, you may be subject to a $250 no show fee.**

- **ARRIVE AT 8:00 PM:**
  The outside doors lock at 9:00 pm, so don't be late! If you are running late, **PLEASE CALL US: DALLAS = 469-283-1144 / HEATH = 469-283-1238.**

- **PLEASE HAVE CLEAN & DRY HAIR:**
  The technologist will be attaching a few sensors to your scalp to record brain waves and your hair must be clean and dry. **Please ensure we can access the scalp**. If you wear a wig or hairpiece please inform our scheduling dept.

- **PLEASE BRING SLEEPING CLOTHES:**
  There will be another patients testing in the center that night and out of courtesy to all, we request appropriate bed clothes. **For testing purposes you will want to wear a separate top and bottom as opposed to a gown.** Also, feel free to bring your favorite pillow or teddy.

- **PLEASE CONTINUE TAKING YOUR MEDICATIONS:**
  Unless otherwise instructed by your doctor, continue taking your medications – including any prescribed sleep aid. Avoid antihistamines (i.e. Benadryl).

- **FEEL FREE TO BRING A SNACK:**
  There is a small refrigerator and microwave available, but please… **no caffeine before bed!**

- **IN THE MORNING:**
  We will try to get you up at your normal wake up time, however the technologist MAY need to continue the recording based on the findings **There will be a washable residue left in your hair.** We do have a shower at the facility and you are welcome to take a shower prior to departure. You may also want to bring an old hat to wear for your departure.

- **FOLLOWING THE STUDY:**
  The study will be prepared and forwarded to the doctor for interpretation next day. A member from our staff will contact you to let you know what's next.

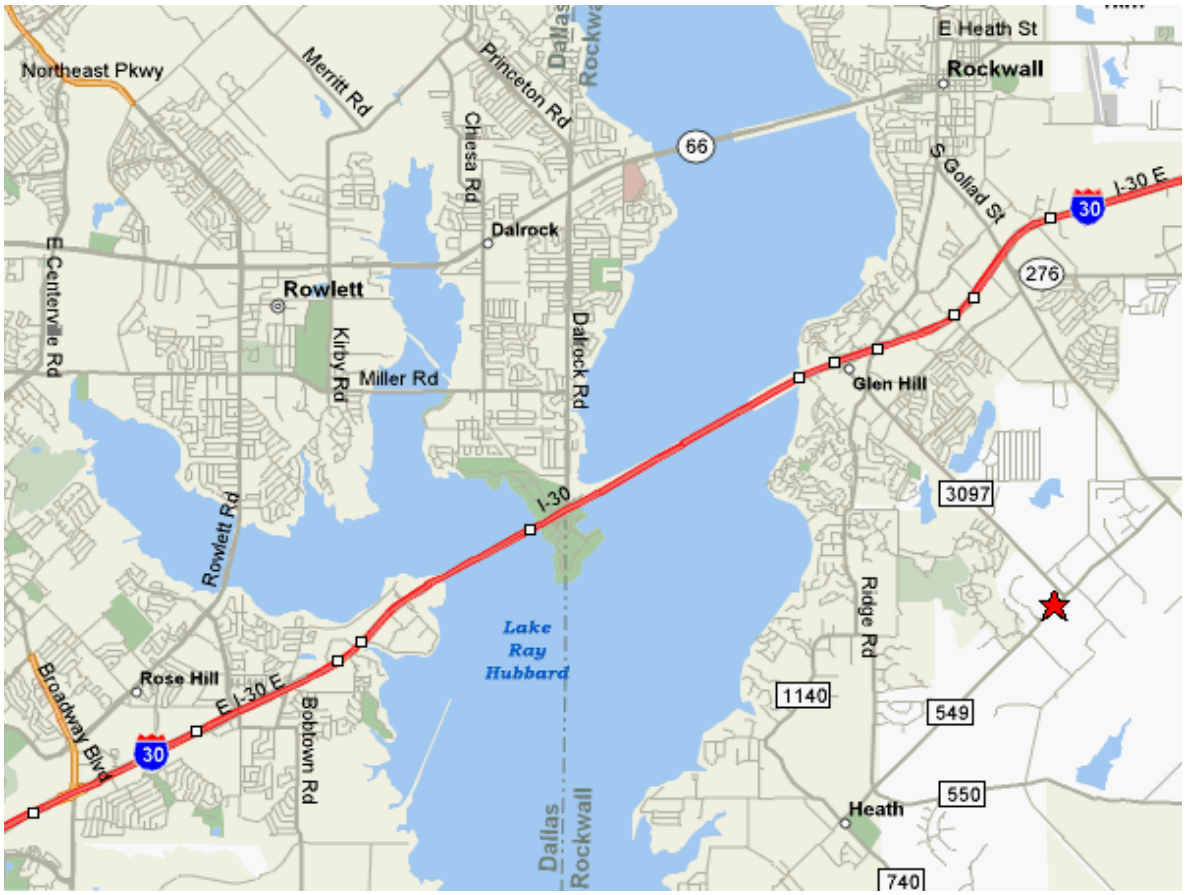
HEATH OFFICE

4 Better Sleep Center

6435 South FM 549, Suite 202

Heath, Texas 75032

469-698-4055



From Dallas:

Take I 30 East toward Texarkana, go over lake and exit 67A Village Dr./Horizon Road, take a right on Horizon Road, Horizon Road becomes FM 3097, stay on Horizon Road for about 3 miles until you come to a light (FM 549), go straight over FM 549 and we are the first parking lot on the right in the 2 story Baylor office building.

Enter the building and go up to the second floor and we are in suite 202.

If you arrive after 9:00 p.m. the front doors will be locked, but you may go to the side of the building where there is a door with a doorbell - ring it and the tech will come down and get you.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL 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 MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **January 1, 2007**, 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 that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised 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 Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. 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 protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you **25¢** for each page, **$15.00** per hour for staff time to locate and copy your protected health information, and postage if you want the copies mailed to you. If the Practice keeps your health information in electronic form, you may request that we send it to you or another party in electronic form. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your non-electronic protected health information for purposes other than treatment, payment, health care operations and certain other activities during the past six (6) years. For disclosures of electronic health information, our duty to provide an accounting only covers disclosures after January 1, 2011 [January 1, 2014] and only applies to disclosures for the three (3) years preceding your request. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. Except as noted herein, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). We are required to accept and follow requests for restrictions of health information to insurance companies if you have paid out-of-pocket and in full for the item or service we provide to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must

accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Notice of Unauthorized Disclosures: If the Practice causes or allows your health information to be disclosed to an unauthorized person, and such may cause harm to you, the Practice will notify you of this and help you mitigate the effects.

Questions and Complaints

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

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. 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 protect the privacy of your protected 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.

Dr. P. Terrence Moore, M.D.
Financial Policies

Thank you for choosing Dr. Moore and 4 Better Sleep for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible. Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy, to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-authorizations, limits on equipment, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payers regardless of whether or not our physicians participate.
If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of- pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage
Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records. Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.
Our doctors belong to many insurance plans but participation differs by doctor. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, we ask that you provide payment on the date of service. We will help you find out if you have out-of-network benefits and submit a claim to your plan on your behalf. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.
Address Change
It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.
Co-payments/Co-insurances/Deductibles
You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.
Other Bills
You may receive services such as EEG testing, sleep testing, neuropsychological testing, radiology testing, pathology, or other services. There will be additional charges for these services.
If you have questions, you may contact the billing office at (214) 466-7222 option 6.

Payments
Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card *(American Express, Discover, MasterCard or Visa)*. Returned checks are subject to a fee.

Non-Medical Fees
Additional fees may apply to the following:

Late Payments - $15.00
Returned Checks- $25.00
Copying of medical records – $50.00
Completion of disability or other forms - $25.00

Missed Appointments
We require **2 business days** cancellation notice. If you miss your appointment, or do not cancel with the required notice, additional fees may apply:

Office Visit: $50.00
New Patient Visit: $50.00
Office Procedure: $75.00
Sleep Study: $250.00

Out-of Network Providers
If the doctor is not in your insurance plan, the following apply:

Full payment is due at the time of service for all visits.

Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients. Any service not covered by your plan is your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds
A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office at (214) 466-7222 option 6.

Failure to Pay
If you do not pay your bill, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you need to contact them directly to settle your balances.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our staff for more details or call our billing office at (214)466-7222 option 5.

*Dr. Paul Moore c/o 4 Better Sleep reserve the right to modify the financial policies.

Dr. P. Terrence Moore, M.D.
& 4 Better Sleep

May we leave personal/medical information on your phone? Circle Yes or No.

Home: Yes / No
Cell: Yes / No

Disclosure of Personal Health Information (PHI)

- ❑ I authorize the disclosure of my protected health information to:

NAME:_____RELATION:_____

NAME:_____RELATION:_____

NAME:_____RELATION:_____

NAME:_____RELATION:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ , authorize the disclosure of my medical and/or other personal information necessary to process my claims and payment of medical benefits to my treating physician or supplier for services rendered by Dr. Moore.

I,_____ , have received and understood a copy of the Notice of Privacy Practices.

Acknowledgement of Receipt of Financial Policies

I,_____ , have received and understood a copy of the Financial Policies.

_____ _____
Signature of Patient Date

If Patient is a Minor:

_____
Signature of Legal Guardian

_____
Relationship to Patient