4BETTERSLEEP
CENTERS
P. TERRENCE MOORE. MD. FAASM

To our patients,

Thank you for entrusting Dr. Moore and 4 Better Sleep with your medical care! We are thrilled to have you join our practice, and we look forward to helping you achieve your best possible sleep and overall health.

At 4 Better Sleep, we understand the crucial role that restful sleep plays in your well-being. Dr. Moore and our dedicated team are here to provide you with personalized care and the most effective treatments to help you sleep soundly and feel rejuvenated. Whether you're dealing with a sleep disorder or just looking to improve your sleep quality, you're in great hands.

Before your upcoming appointment, we kindly ask that you complete all the necessary new patient paperwork. This helps us ensure that we can provide you with the best care possible right from the start. Please have all forms completed and submitted prior to your appointment to help things run smoothly on the day of your visit.

Appointment Confirmations:
Our office will contact you via text or call to confirm your appointment within 72 hours of the scheduled time. Please ensure that you confirm within 24 hours. Appointments that remain unconfirmed may be subject to cancellation or additional fees.

Late Appointment Arrivals:
As a courtesy to others, we reserve the right to reschedule your appointment after a 10-minute grace period. Appointments missed or not cancelled within 48 hours may be subject to additional fees.

Consultations: $150.00
Follow-ups: $50.00
Office Procedures: $75.00
Sleep Studies: $250.00

If you have any questions or concerns, please don't hesitate to contact us at 214-466-7222. We're here to support you every step of the way.

Again, we thank you for choosing Dr. Moore and 4 Better Sleep. We're Excited to help you on your path to better sleep and better health!

Many thanks,

Paul Terrence Moore, MD, FAASM

4 Better Sleep Centers
214-466-7222
Info@4bettersleep.com

PATIENT DEMOGRAPHICS

Full name:	Date of birth:
	Email address:
Sex: ☐Male ☐ Female ■ Prefer not to say	Phone number:
Height: Weight:	Secondary phone number:
Race: Ethnicity:	Preferred Method of Communication: ○ Phone ○ Email
Emergency Contact:	Street Address:
Phone Number:	How did you hear about us?

PATIENT INSURANCE INFORMATION

Primary care physician:	Preferred pharmacy:
Phone number:	Pharmacy phone number:
Referring physician:	Pharmacy street address:
Phone number:	
Primary Insurance:	**Secondary Insurance:**
Policy #	Policy #
Group #	Group #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Phone Number for Provider benefits:	Phone Number for Provider benefits:

PERSONAL HISTORY

What is your chief complaint?
Do you experience constitutional symptoms such as fever or weight loss?
Have you had any surgeries?
Do you currently smoke, or have you ever smoked?
Do you drink alcohol? If so, how many per week?
Do you drink caffeinated beverages? If so, how many per week?
Do you engage in physical activity beyond your normal daily routine? How much?

SCHEDULING ASSESSMENT FORM:

If you do not speak English, you will need to arrange for a translator to be present during your sleep study

Do you have any specific nutritional needs during the night or known allergies? If yes, please provide details.
Will arrangements need to be made for another person or caretaker to stay overnight at the facility?
Do you use a dental device? If so, what is it for?
Do you have any visual or hearing impairments, or do you use a wheelchair?

PREVIOUS SLEEP HISTORY:

Have you ever undergone a sleep study? ☐ Yes ☐ No If so, what was the outcome?	What is your normal sleep schedule? Weekdays: Weekends:
Are you currently using CPAP? ☐ Yes ☐ No	Are you currently using supplemental oxygen? ☐ Yes; Current 02 vendor: ☐ No

CPAP CHECKLIST

If you currently have CPAP, are you experiencing any of the following issues?

Current pressures: _____

Current DME vendor:

☐ Air Swallowing	☐ Discomfort
☐ Airway Dryness	☐ Leaking
☐ CPAP Malfunctioning	☐ Nasal Breathing Problems
☐ Difficulty Exhaling	☐ Not Enough Air

Experienced any of the following during sleep?

- ☐ Diagnosis of any other sleep disorder
- ☐ Difficulty sleeping on your back
- ☐ Dream enactments
- ☐ Episodes of involuntary eating or drinking during sleep
- ☐ Hallucinations
- ☐ Loud noises or a sense of explosion in the head
- ☐ Narcolepsy
- ☐ Recurrent nightmares
- ☐ Restless leg syndrome (RLS)
- ☐ Shouting
- ☐ Sleep paralysis (inability to speak or move)
- ☐ Sleep talking
- ☐ Sleep walking
- ☐ Waking up crying, screaming, or in fear

Diagnosed with any of the following?

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/ Fainting/ Weakness
- ☐ Epilepsy
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Neuromuscular disease (e.g. Parkinson's disease, ALS, MS)
- ☐ Pulmonary disease
- ☐ Seizures
- ☐ Stroke

Family History:

- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease or stroke
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Thyroid disease

Previous Testing:

- ☐ Blood Tests (Specify)
- ☐ Bone Density
- ☐ Carotid Doppler
- ☐ Cerebral Arteriogram
- ☐ CT scan
- ☐ EEG (brain wave recording)
- ☐ Echocardiogram
- ☐ EMG and nerve conductions
- ☐ EP (evoked potential) study
- ☐ LP (Spinal Tap)
- ☐ MRI
- ☐ Myelogram
- ☐ Other:

CURRENT MEDICATION LIST:

Medication	Start date	Dose/Frequency	Prescribing Physician	Comments

List any allergies you have to medications:

MODIFIED F.O.S.Q.

	Extremely			No
Do you have difficulty concentrating on the things you do because you are sleepy or tired?	1☐	2☐	3☐	4☐
Do you generally have difficulty remembering things because you are sleepy or tired?	1☐	2☐	3☐	4☐
Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?	1☐	2☐	3☐	4☐
Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?	1☐	2☐	3☐	4☐
Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?	1☐	2☐	3☐	4☐
Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	1☐	2☐	3☐	4☐
Do you have difficulty watching a movie or video because you become sleepy or tired?	1☐	2☐	3☐	4☐
Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	1☐	2☐	3☐	4☐
Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?	1☐	2☐	3☐	4☐
Has your mood been affected because you are sleepy or tired?	1☐	2☐	3☐	4☐

TOTAL:

Epworth Sleepiness Scale

	No chance of dosing off		High chance of dosing off	
Sitting and reading	0☐	1☐	2☐	3☐
Watching TV	0☐	1☐	2☐	3☐
Sitting inactive in a public place (e.g., a theater or a meeting)	0☐	1☐	2☐	3☐
As a passenger in a car for an hour without a break	0☐	1☐	2☐	3☐
Lying down to rest in the afternoon when circumstances permit	0☐	1☐	2☐	3☐
Sitting and talking to someone	0☐	1☐	2☐	3☐
Sitting quietly after lunch without alcohol	0☐	1☐	2☐	3☐
In a car, while stopped for a few minutes in traffic	0☐	1☐	2☐	3☐

TOTAL:

Insomnia Severity Index

	Not Severe				Very Severe
During the past two weeks, how often have you had trouble falling asleep?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how often have you had trouble staying asleep?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how often did you wake up too early and not be able to get back to sleep?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how often have you had trouble falling back to sleep after waking up during the night?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how much of a problem has it been for you to stay awake and alert during the day due to poor sleep?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how concerned or distressed have you been about your sleep?	0☐	1☐	2☐	3☐	4☐
During the past two weeks, how much do you think your sleep problem has affected your daily functioning?	0☐	1☐	2☐	3☐	4☐

TOTAL:

Fatigue Severity Scale

	Disagree						Agree
My motivation is lower when I am fatigued.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Exercise brings on my fatigue.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
I am easily fatigued.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Fatigue interferes with my physical functioning.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Fatigue causes frequent problems for me.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
My fatigue prevents sustained physical functioning.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Fatigue interferes with carrying out certain duties and responsibilities.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Fatigue is among my most disabling symptoms.	1☐	2☐	3☐	4☐	5☐	6☐	7☐
Fatigue interferes with my work, family, or social life.	1☐	2☐	3☐	4☐	5☐	6☐	7☐

TOTAL:

STOPBANG

	Yes 5 - 8 (High risk of OSA)	Yes 3 - 4 (Intermediate risk of OSA)	Yes 0-2 (Low risk of OSA)
Do you Snore Loudly (loud enough to be heard through closed doors)?	Yes ☐		No ☐
Do you often feel Tired, fatigued, or sleepy during daytime?	Yes ☐		No ☐
Has anyone Observed you stop breathing during your sleep?	Yes ☐		No ☐
Do you have or are you being treated for high blood Pressure?	Yes ☐		No ☐
Is your BMI more than 35 kg/m2?	Yes ☐		No ☐
Is your Age over 50 years old?	Yes ☐		No ☐
Is your Neck circumference greater than 15.75 inches?	Yes ☐		No ☐
Gender: Are you male?	Yes ☐		No ☐

TOTAL 'YES":

P.Terrence Moore, MD, FAASM and 4 Better Sleep Centers
HIPAA Electronic Communication Consent Form

The purpose of this form is to obtain your consent to communicate with you electronically, including via email, text messages and marketing emails. This is to ensure that you understand and acknowledge the risks and your rights under HIPAA (Health Insurance Portability and Accountability Act) when receiving health-related communication.

Email Communication:

I understand that emails may be sent either unencrypted or encrypted, depending on the nature of the communication.

i. **Encrypted Email**: These messages are protected and encrypted to help ensure the confidentiality of my PHI.

ii. **Unencrypted Email**: These messages may not be secure, and while efforts will be made to protect the confidentiality of my PHI, there is a risk of unauthorized access.

_____ INITIAL

I acknowledge that there is a risk of unauthorized access to unencrypted email communications and that the confidentiality of my health information cannot be guaranteed.

☐ I consent to receive **unencrypted** email communication

Email Address: _____

☐ I consent to receive **encrypted** email communication

Email Address: _____

☐ I **do not** consent to receive email communication

Text Message Communication:

I consent to receive text message communications regarding my healthcare, including appointment reminders, prescription notifications, and other health-related reminders.

_____ INITIAL

I understand that standard text messaging rates may apply, depending on my mobile carrier. While text messages are generally encrypted, I acknowledge that there is still a potential risk of unauthorized access to my health information through this medium.

☐ I consent to receive **text message** communication

Email Address: _____

☐ I **do not** consent to receive **text message** communication

Marketing Email Communication:

_____ INITIAL

I consent to receiving marketing email updates, newsletters and promotional offers related to health services, products or events. I understand that these emails will not contain personal health information but instead will be related to general health services rendered.

☐ I consent to receive marketing email communications

Email Address: _____

☐ I **do not** consent to receive marketing email communications

Patient Acknowledgment:

I understand that I have the right to revoke my consent for any or all communication methods at any time without affecting my treatment, payment, or healthcare operations, by contacting the office via phone or email. While efforts will be made to protect my health information, I acknowledge that electronic communications such as email and text messages are not fully secure and may be at risk of unauthorized access. I accept these risks and provide my informed consent.

PATIENT NAME	PATIENT SIGNATURE	DATE
GUARDIAN NAME	GUARDIAN SIGNATURE	DATE

P.Terrence Moore, MD, FAASM and 4 Better Sleep Centers
Disclosure of Personal Health and Medical Information Form

This form authorizes the disclosure of your personal health and medical information to designated individuals or entities for the purposes outlined below, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy laws.

Authorization to Disclose Personal Health Information

I, the undersigned, hereby authorize the release of my medical and health information to the following person(s) or organization(s):

☐ I consent to the release of my health information to the following recipient:

Name: _____

Relationship to Patient: _____

I understand that I can revoke this authorization at any time by submitting a written request, and the revocation will not affect disclosures made prior. I also understand that once my health information is disclosed, it may no longer be protected by federal privacy regulations and could be shared with others.

I acknowledge that I have the right to refuse to sign this authorization without it affecting my ability to receive treatment or payment for services from an insurance company or other responsible party. I have read and understand this form and authorize the release of my medical information as described.

PATIENT NAME	PATIENT SIGNATURE	DATE
GUARDIAN NAME	GUARDIAN SIGNATURE	DATE

P.Terrence Moore, MD, FAASM and 4 Better Sleep Centers
Notice of Privacy Practices

We understand that health information about you and your health care is personal and are committed to protecting health information about you. Your personal health information is protected by the Health Insurance and Portability Accountability Act ("HIPAA") and other privacy laws and regulations. This notice will tell you how we may use and disclose protected health information about you. Protected health information means any health information about you that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this notice, we call all of that protected health information ("PHI") "medical information."

This notice also will tell you about your rights and our duties with respect to medical information about you. In addition, it will tell you how to complain to us and the Department of Health and Human Services if you believe we have violated your privacy rights.

How We May Use and Disclose Medical Information About You

We use and disclose medical information about you for different purposes. Each of those purposes is described below.

For Treatment: We may use medical information about you to provide, coordinate or manage your health care and related services by both us and other health care providers. We may disclose medical information about you to doctors, nurses, hospitals and other health facilities who become involved in your care. We may consult with other health care providers concerning you and, as part of the consultation, share your medical information with them. Similarly, we may refer you to another health care provider and, as part of the referral, share medical information about you with that provider. For example, we may conclude you need to receive services from a physician with a particular specialty. When we refer you to that physician, we also will contact that physician's office and provide medical information about you to them, so they have information they need to provide services for you.

For Payment: We may use and disclose medical information about you so we can be paid for the services we provide to you. This can include billing you, your insurance company or a third-party payor. For example, we may need to give your insurance company information about the health care services we provide to you so your insurance company will pay us for those services or reimburse you for the amounts you have paid. We also may need to provide your insurance company or a government program, such as Medicare or Medicaid, with information about your medical condition and the health care you need to receive to determine if you are covered by that insurance or program.

For Health Care Operations: We may use and disclose medical information about you for our own health care operations. These are necessary for us to operate and to maintain quality health care for our patients. For example, we may use medical information about you to review the services we provide and the performance of our employees in caring for you. We may disclose medical information about you to train our staff, volunteers and students working for P. Terrence Moore, M.D., FAASM. We may also use the information to study ways to more efficiently manage our organization.

How We Will Contact You: Unless you tell us otherwise in writing, we may contact you by either telephone or by mail either at your home or your workplace. At either location, we may leave messages for you on the answering machine or voice mail. If you want to request that we communicate to you in a certain way or at a certain location, see the section "Right to Receive Confidential Communications" contained in this Notice.

Treatment Alternatives: We may use and disclose medical information about you to contact you about treatment alternatives that may be of interest to you.

Health Related Benefits and Services: We may use and disclose medical information about you to contact you about health-related benefits and services that may be of interest to you.

Marketing Communications: We may use and disclose medical information about you only to communicate directly with you about a service provided through our office. This may include:

- to describe a service that is provided by us;
- for treatment that is provided to you by us; or
- for services provided by us to assist you by doing such things as directing or recommending alternative treatments, therapies, health care providers or settings of care.

We may communicate directly to you about products and services in a face-to-face communication by us to you, or in writing, and we may communicate about products or services in the form of a promotional gift of nominal value.

Any marketing of our services to you utilizing your medical information will be done only with your written authorization and consent.

Individuals Involved in Your Care: We may disclose to a family member, other relative, a close personal friend or any other person identified by you, medical information about you that is directly relevant to that person's involvement with your care, or payment related to your care, as long as you have been given an opportunity to agree or object, or we can reasonably infer from the circumstances that you do not object. We also may use or disclose medical information about you to notify, or assist in notifying, those persons of your location, general condition or death. If there is a family member, other relative, or close friend to whom you do not want to disclose medical information about you, please notify P. Terrence Moore, M.D., FAASM., or tell our staff member who is providing care to you.

Required by Law: We may use or disclose medical information about you when we are required to do so by law and the disclosure complies with the requirements of such law.

Public Health Activities: We may disclose medical information about you for public health activities and purposes. This includes reporting medical information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, injury or disability. It includes a public health authority or agency that is authorized to receive reports of child abuse and neglect. It also includes reporting for purposes of activities related to the quality, safety or effectiveness of a United States Food and Drug administration regulated product or activity. There are other public health authorities to whom we may report or disclose your medical information. The above are simply examples.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information about you to a government authority authorized by law to receive reports of abuse, neglect or domestic violence if we believe you are a victim of abuse, neglect or domestic violence. This will occur t o the extent the disclosure is required by law, and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims.

Health Oversight Activities: We may disclose medical information about you to a health oversight agency, such as the Texas Department of Health and Human Services or a licensing or regulatory agency, for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs and entities subject to various government regulations.

Judicial and Administrative Proceedings: We may disclose medical information about you in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal; however, we will only disclose the medical information expressly authorized by the court order. We may also disclose medical information about you in response to a subpoena, discovery request or other legal process. In these cases, we will seek satisfactory assurance from the party seeking your medical information that you have been given notice or reasonable efforts have been made to secure a protective order on your behalf.

Disclosures for Law Enforcement Purposes: Under certain circumstances, we may disclose medical information about you to a law enforcement official for law enforcement purposes. Some examples include the following: response to a court order, grand jury subpoena, administrative subpoena, court ordered warrant, or civil investigative demand; reporting certain types of wounds or injuries; or disclosures made due to crimes that occur on P. Terrence Moore, M.D., FAASM., premises.

Coroners and Medical Examiners: We may disclose medical information about you to a coroner or medical examiner for purposes such as identifying a deceased person and determining cause of death.

Funeral Directors: We may disclose medical information about you to funeral directors as necessary for them to carry out their duties.

Organ, Eye or Tissue Donation: To facilitate organ, eye or tissue donation and transplantation, we may disclose medical information about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue.

Research (if applicable): Under certain circumstances, we may use or disclose medical information about you for research. Before we disclose medical information for research, the research will have been approved through an approval process that evaluates the needs of the research project with your needs for privacy of your medical information. We may, however, disclose medical information about you to a person who is preparing to conduct research to permit them to prepare for the project, but no medical information will leave P. Terrence Moore, M.D., FAASM, during that person's review of the information.

To Avert Serious Threat to Health or Safety: We may use or disclose protected health information about you if we believe the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We also may release information about you if we believe the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

Specialized Government Functions: We may disclose medical information about you to authorized federal officials for national security reasons, including the conduct of intelligence, counterintelligence and other national security activities authorized by law. There are other permitted disclosures that may occur relating to matters of national security.

Workers Compensation: We may disclose medical information about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

Other Uses and Disclosures: Your written authorization will be obtained for: (a) most uses and disclosures of psychotherapy notes (to the extent that P. Terrence Moore, M.D., FAASM, records or maintains these types of notes); (b) uses and disclosures of your medical information for marketing purposes; and (c) disclosures that constitute a sale of your medical information. In addition, other uses and disclosures not described in this notice or not allowed by federal and state law will be made only with your written authorization. You may revoke such an authorization at any time by contacting P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243, in writing of your desire to revoke it. However, if you revoke such an authorization, it will not affect any actions already taken by us in reliance on it.

Your Rights with Respect to Medical Information About You

You have the following rights with respect to medical information that we maintain about you.

Right to Request Restrictions: You have the right to request that we restrict the uses or disclosures of medical information about you to carry out treatment, payment or health care operations. You also have the right to request that we restrict the uses or disclosures we make to: (a) a family member, other relative, a close friend or any other person identified by you; or (b) to public or private entities for disaster relief efforts. For example, you could ask that we not disclose medical information about you to your brother or sister.

If the disclosure is not required by law, you have the right to restrict the disclosure of your medical information to a health plan if the disclosure is being made for payment or health care operations purposes and you have already paid for the item or service in full out of pocket.

To request a restriction, you may do so at any time. If you request a restriction, you should do so in writing to P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243. You should tell us: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and (c) to whom you want the limits to apply (for example, disclosures to your sibling).

We are not required to agree to any requested restriction except your right to restrict disclosure of your medical information to a health plan as described above. However, if we do agree, we will follow that restriction unless the information is needed to provide emergency treatment. Even if we agree to a restriction, either you or we can later terminate the restriction.

Right to Receive Confidential Communications: You have the right to request that we communicate medical information about you to you in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. We will not require you to tell us why you are asking for the confidential communication.

If you want to request confidential communications, you must do so in writing by sending the request to P. Terrence Moore, M. D., FAASM., 8722 Greenville Avenue Suite #102, Dallas, TX 75243. Your request must state how or where you can be contacted.

We will accommodate your request. However, we may, when appropriate, require information from you concerning how payment will be handled. We also may require an alternate address or other method to contact you .

Right to Inspect and Copy: You have the right to inspect and obtain a copy of medical information about you.

To inspect or copy medical information about you, you must submit your request in writing to P. Terrence Moore, M.D., FAASM., 8722 Greenville Avenue Suite #102, Dallas, TX 75243. Your request should state specifically what medical information you want to inspect or copy. If you request a copy of the information, we may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing.

We will act on your request within thirty (30) calendar days after we receive your request. If we grant your request, in who le or in part, we will inform you of our acceptance of your request and provide access and copies.

We may deny your request to inspect and copy medical information if the medical information involved is information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding, or if we make determination that it can be denied under state or federal law.

If we deny your request, we will inform you of the basis for the denial, how you may have our denial reviewed and how you may complain. If you request a review of our denial, it will be conducted by a licensed health care professional designated by us who was not directly involved in the denial. We will comply with the outcome of that review.

Right to Amend: You have the right to ask us to amend medical information about you. This only applies to information generated by P. Terrence Moore, M.D., FAASM. To change records generated by another provider (such as a physician), you must contact that provider.

You have this right for so long as the medical information is maintained by us.

To request an amendment, you must submit your request in writing to P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243. Your request must state the amendment desired and provide a reason in support of that amendment.

We will act on your request within sixty (60) calendar days after we receive your request. If we grant your request, in whole or in part, we will inform you of our acceptance of your request and provide access and copying.

If we grant the request, in whole or in part, we will seek your identification of, and agreement to share, the amendment with other relevant persons. We also will make the appropriate amendment to the medical information by appending it to your existing medical record.

We may deny your request to amend medical information about you. We may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, we may deny your request to amend medical information if we determine that information:

- was not created by us, unless the person or entity that created the information is no longer available to act on the requested amendment;
- is not part of the medical information maintained by us;
- would not be available for you to inspect or copy; or
- is accurate and complete.

If we deny your request, we will inform you of the basis for the denial. You will have the right to submit a statement of disagreement with our denial. We may prepare a rebuttal to that statement. Your request for amendment, our denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the medical information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, we may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that we include your request for amendment and our denial with any future disclosures of the information. We will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the medical information involved.

You also have the right to complain about our denial of your request.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of medical information about you. The accounting may be for up to six (6) years prior to the date on which you request the accounting. Certain types of disclosures are not included in such an accounting, which include, but are not limited to the following:

- Disclosures to carry out treatment, payment and health care operations;
- Disclosures of your medical information made to you;
- Disclosures that are incidental to another use or disclosure;
- Disclosures that you have authorized;
- Disclosures for our facility directory or to persons involved in your care;
- Disclosures for disaster relief purposes;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials having custody of you;
- Disclosures that are part of a limited data set for purposes of research, public health, or health care operations (a limited data set is where things that
- would directly identify you have been removed); and
- Disclosures made six (6) years prior to the date we receive your request.

Under certain circumstances, your right to an accounting of disclosures to a law enforcement official or a health oversight agency may be suspended. Should you request an accounting during the period of time your right is suspended, the accounting would not include the disclosure or disclosures to a law enforcement official or to a health oversight agency.

To request an accounting of disclosures, you must submit your request in writing to P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request.

Usually, we will act on your request within sixty (60) calendar days after we receive your request. Within that time, we will either provide the accounting of disclosures to you or give you a written statement of when we will provide the accounting and why the delay is necessary.

There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, we may charge you for the cost of providing the list. If there will be a charge, we will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

Right to Copy of this Notice: You have the right to obtain a paper copy of our Notice of Privacy Practices. You may obtain a paper copy even though you agreed to receive the notice electronically. You may request a copy of our Notice of Privacy Practices at any time.

You may obtain a copy of our Notice of Privacy Practices over the Internet at our web site, https://www.4bettersleep.com. To obtain a paper copy of this notice, contact P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243.

Our Duties

Generally: We are required by law to maintain the privacy of medical information about you and to provide individuals with notice of our legal duties and privacy practices with respect to medical information.

You have a right to receive notifications of any breach of your unsecured medical information. A breach of your unsecured medical information generally means that the medical information was used or disclosed in a way that was not permitted by law, and the medical information was readable or decipherable by the unauthorized person or entity.

We are required to abide by the terms of our Notice of Privacy Practices in effect at the time.

Our Right to Change Notice of Privacy Practices: We reserve the right to change this Notice of Privacy Practices. We reserve the right to make the new notices. provisions effective for all medical information that we maintain, including that created or received by us prior to the effective date of the new notice.

Availability of Notice of Privacy Practices: A copy of our current Notice of Privacy Practices will be posted at our office as well as on our web site, https://www.4bettersleep.com. At any time, you may obtain a copy of the current Notice of Privacy Practices by contacting P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243 or by calling (214) 466 -7222.

Complaints: You may complain to us and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. To file a complaint with us, contact P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dall as, TX 75243 or by calling (214) 466-7222. Please follow up any complaint made by telephone in writing.

To file a complaint with the United States Secretary of Health and Human Services, send your complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Washington, D.C. 20201 or on the internet at https://www.hhs.gov/hipaa/filing-a-complaint/index.html. You may also contact the regional office of the Health and Human Services Office of Civil Rights at Southwest Region, Office for Civi l Rights, U.S Department of Health and Human Services, 1301 Young Street, Suite #106, Dallas, TX 75202, voice phone (800) 368 -1019, Facsimile (202) 619-3818, TDD (800) 537-7697 or e-mail at ocrmail@hhs.gov.

You will not be retaliated against for filing a complaint.

Questions and Information: If you have any questions or want more information concerning the regional office of the Health and Human Services Office of Civil Rights you can contact us in writing at P. Terrence Moore, M.D., FAASM, 8722 Greenville Avenue Suite #102, Dallas, TX 75243 or by calling (214) 466 -7222.

Authorization of Receipt of Notice of Privacy Practices

By signing below, I, _____ , acknowledge that I have received P. Terrence Moore, MD, FAASM's Notice of Privacy Practices, Effective April 2025, which explains how my personal health information may be used and disclosed, and my rights regarding that information. I understand that I am responsible for reviewing this notice and can contact the office if I have any questions or need further clarification.

PATIENT NAME	PATIENT SIGNATURE	DATE
GUARDIAN NAME	GUARDIAN SIGNATURE	DATE

P.Terrence Moore, MD, FAASM and 4 Better Sleep Centers
Practice Financial Policy

The following statement outlines our Financial Policy, which you must read, agree to, and sign prior to treatment. This policy applies to all services rendered by our office.

Patient Payment Policy Guidelines

Patients and/or their guardians are financially responsible for all charges, regardless of third-party involvement. Full payment is due at the time of service unless prior insurance billing arrangements have been made. Patients with insurance will be required to pay all out-of-pocket expenses at the time of service. We accept the following payment methods: Cash, Check, Bank Debit Cards, and the following credit cards: Visa, AMEX, MasterCard, and Discover.

Patient Responsibilities and Financial Policies

Provide Accurate Information: You are responsible for providing accurate and complete information regarding your health history, mailing address, health insurance, and other billing details. If any of your information changes (e.g., name, address, phone number, insurance coverage), you must inform our practice immediately. Insurance denials or billing errors due to patient-supplied information will result in the account balance being transferred to the patient's financial responsibility.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services in full at the time of service unless a satisfactory payment arrangement has been made with our billing manager in advance.

Know Your Insurance Coverage, Benefits, and Referral Requirements: Your health insurance is a contract between you and your insurance provider. You are responsible for understanding your insurance coverage, benefits, and referral requirements to receive diagnostic and therapeutic services from our physicians. You must secure any necessary referrals, pre-authorizations, or pre-certifications from your primary care physician or health plan before services are rendered. If we do not receive the required authorization before your appointment, you will be required to sign a waiver acknowledging your financial responsibility, or the appointment maybe rescheduled. Any coverage or payment disputes are between you and your insurance provider. Please present your insurance ID card at the time of registration for each office visit.

Patients with Private Insurance/Medicare: Our physicians participate in the Medicare Program and with most major insurance companies. We will file claims with your insurance provider, provided you authorize the "assignment of benefits" below for payment directly to our practice. For participating insurance plans, we will accept payment based on contractual agreements. For non-participating or out-of-network plans, full payment is due at the time of service, or the balance will be billed to you after insurance payment.

Patient Payment Agreement

I understand that I am financially responsible for all charges, regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed "non-covered" by my insurance provider at the time of service. If my insurance has not made a payment within 60 days, the outstanding balance will become my responsibility. Should any balance arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at the time of service, or any other reason, I agree to pay all charges within 15 days of notification.

I understand that If I fail to make payment or arrange payment within 60 days, the balance will be considered delinquent and subject to legal action. I understand that delinquent accounts will incur a 1.5% monthly interest charge (18% APR) and may result i n the dismissal of the patient from our care. If my account is sent to collections, I agree to pay all associated costs, including court fees, attorney fees, and accrued interest. I understand that if my check is returned for any reason, a $25.00 processing fee will be charged, in addition to the outstanding balance.

Additional Fees

I agree to pay the following fees or medical services: $150.00 for a new patient visit, $50.00 for a follow-up visit, $75.00 for office procedures, and $250.00 for sleep studies that are not canceled at least 48 hours in advance. To cancel your appointment you can call 214.466.7222 or email Info@4bettersleep.com.

Per the Texas Medical Board (TMB), I understand that copies of my medical records may be obtained with advance notice for a fee of $25 for the first 20 pages in paper format, with an additional charge of $0.50 per page for each page beyond the first 20. For electronic records, the maximum fee is $25 for records containing 500 pages or fewer, and $50 for records exceeding 500 pages.

Acknowledgment of Receipt of the Practice Financial Policy

By signing below, in consideration of medical services rendered, I acknowledge receiving the Financial Policy and agree to pay for these services according to the terms outlined above. My signature indicates that I have read and agree with the policy.

_____ SIGNATURE

_____ DATE

4 Better Sleep Centers
214-466-7222
Info@4bettersleep.com