Diagnostic & Treatment Center for Sleep Disorders

19441 Golf Vista Plaza, Suite 230, Lansdowne, VA 20176 • 14141 Robert Paris Court, Chantilly, VA 20151 • 200 N. Glebe Road, Suite 316, Arlington, VA 22203
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Phone: 703 -729-3420 Fax: 703-729-3422 • www.ComprehensiveSleepCare.com

PEDIATRIC PATIENT INFORMATION

Full Name of Your Child: _____ Prefix/Suffix: _____ Todays Date: _____/_____/_____
Child Sex:❑ M / ❑ F Child Date of Birth: _____/_____/_____ Child Age: _____ Child Social Security #: _____-_____-_____
Parent Home Address: _____City: _____State: _____Zip: _____
Parent Home Phone #: _____-_____-_____ Parent Mobile Phone #: _____-_____-_____
Parent Email Address: _____ Parent Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow
Child Language: ❑ English ❑ Spanish ❑ Indian (Hindi/Tamil) ❑ Russian ❑ Other _____
Child Ethnicity: ❑ Caucasian ❑ American ❑ Indian ❑ Asian ❑ African American ❑ Hispanic
❑ Native Hawaiian or ❑ Pacific Islander ❑ Other _____

EMPLOYER | PHARMACY INFORMATION

Parent Employer: _____ Parent Employer Phone #: _____-_____-_____
Child Job Status: ❑ FULL TIME ❑ PART TIME ❑ STUDENT
Parent Employer Address: _____ City: _____State: _____Zip: _____
Child Preferred Pharmacy: _____ Child Pharmacy Phone #: _____-_____-_____
Child Pharmacy Address: _____ City: _____State: _____Zip: _____

CONTACT / GUARANTOR INFORMATION

NEXT OF KIN CONTACT (please check at least one) ❑ Emergency Contact ❑ Next of Kin ❑ Authorized to Seek Treatment
Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____-_____-_____ Relationship to Patient: _____ Sex: ❑ M / ❑ F
Date of Birth: _____/_____/_____ Home Address: _____
Employer: _____ Work Phone #: _____-_____-_____ Job Title: _____

NEXT OF KIN CONTACT (please check at least one) ❑ Emergency Contact ❑ Next of Kin ❑ Authorized to Seek Treatment
Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____-_____-_____ Relationship to Patient: _____ Sex: ❑ M / ❑ F
Date of Birth: _____/_____/_____ Home Address: _____
Employer: _____ Work Phone #: _____-_____-_____ Job Title: _____

If the Guarantor information is left blank, the patient will be assumed to be the responsible/billed party.

GUARANTOR CONTACT (please check at least one) ❑ Guarantor ❑ Policy Holder/Insured
Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____-_____-_____ Relationship to Patient: _____ Sex: ❑ M / ❑ F
Date of Birth: _____/_____/_____ Home Address: _____
Employer: _____ Work Phone #: _____-_____-_____ Job Title: _____

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PHYSICIAN INFORMATION: IMPORTANT PLEASE PROVIDE BOTH PHYSICANS

How did you find us? ❑ Referring or Primary Care Physician ❑ Internet ❑ Advertisement ❑ Insurance Company
❑ Family/Friend: _____

Referring Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____-_____-_____
Fax #: _____-_____-_____

Primary Care Physician: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone #: _____-_____-_____
Fax #: _____-_____-_____

INSURANCE POLICY INFORMATION

Type (please check one only) ❑ Health ❑ Auto ❑ Workers Comp ❑ Other: _____
PRIMARY INSURANCE NAME: _____
Claims Address: _____ Phone #: _____-_____-_____
Policy #: _____ Group #: _____
Policy Holder Information (if different)
Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____
Policy Holder Phone #: _____-_____-_____ Policy Holder SS #: _____-_____-_____

SECONDARY INSURANCE NAME

Type (please check one only) ❑ Health ❑ Auto ❑ Workers Comp ❑ Other: _____
SECONDARY INSURANCE NAME: _____
Claims Address: _____ Phone #: _____-_____-_____
Policy #: _____ Group #: _____
Policy Holder Information (if different)
Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____
Policy Holder Phone #: _____-_____-_____ Policy Holder SS #: _____-_____-_____

TERTIARY INSURANCE NAME (IF APPLICABLE)

Type (please check one only) ❑ Health ❑ Auto ❑ Workers Comp ❑ Other: _____
TERTIARY INSURANCE NAME: _____
Claims Address: _____ Phone #: _____-_____-_____
Policy #: _____ Group #: _____
Policy Holder Information (if different)
Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

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Policy Holder Phone #: _____-_____-_____ Policy Holder SS #: _____-_____-_____

FINANCIAL POLICY

This consent applies to Loudoun Medical Group, PC (herein after referred LMG) d/b/a Comprehensive Sleep Care Center, or any of its affiliates or agents, lenders, or any third party servicer acting for LMG or any of its affiliates.

I hereby authorize my insurance benefits to be paid directly to the physician and/or physician group for which I am financially responsible for all charges. I also consent to the release and re-disclosure of my medical record to enable or facilitate the payment, collection, verification or settlement of my account for any amounts due from me or any third party payor, health maintenance organization, insurer or other health benefit plan.

Our office will provide you a general breakdown of coverage on your first visit and this information will be disclosed to you via a "Call In Form" which you are required to sign. Please note, this information is used for obtaining preliminary insurance information only and this is not a guarantee of benefits; we highly recommend that you contact your insurance carrier to get more specific approval for all services.

****If the "Call in Form" was not reviewed with you at your Initial appointment, please notify the front desk immediately so that this can be provided for you.**

If at any point you change insurance, or your insurance policy terminates or cancels coverage, you will be fully responsible for any and all charges that are not subject to being refiled with any new insurance provided. Most insurance(s) have timely filing requirements that if they are not met we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy.

****If we are unable to refile your claims you will be fully responsible for all charges.** This includes any SECONDARY insurance related information as well.

REFERRAL POLICY

I understand that if my insurance carrier requires a written "Insurance Referral" from my Primary Care Physician, I am responsible for obtaining the insurance referral prior to being seen in our office and prior to be testing.

We recommend that all patients call and confirm this directly with your health insurance or check with your PCP office ahead of time. If an "insurance referral" has not been obtained before my appointment, I will be asked to sign a "Waiver Form" acknowledging that if the referral is not able to be obtained timely I will be financially responsible for the charges incurred.

CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

*Office Visit appointment not cancelled within (48) business hours will be charged $30.00 cancellation fee-this fee is NOT billable to your insurance carrier.

*Sleep Study related appointments not cancelled within (72) business hours will be charged $150.00 cancellations fee-this fee is NOT billable to your insurance carrier. For all Sleep Study related appointments, we have arranged in advance to have a Registered Polysomnogram Sleep Technician available to provide your Sleep Study.

* **If you must cancel or reschedule your appointment, we ask that you contact us directly at 703.729.3420, OPTION# 3 (Monday-Friday 8:00am-4:00pm).**

Print Name: _____ Date: _____/_____/_____ Signature: _____

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MEDICAL RECORDS POLICY

MEDICAL RECORDS POLICY: NO CHARGE FOR THE FIRST (10) PAGES, THEN $0.50 PER PAGE UP TO (50) PAGES AND $0.25 A PAGE THEREAFTER FOR COPIES FROM PAPER, PLUS A $10.00 RETRIEVAL/PROCESSING FEE. ALL POSTAGE AND SHIPPING COSTS ARE INCLUDED.

VA Code: 32.1-127.1:03 Health care records must be made available electronically only as authorized by the HITECH Act and HIPAA. A health care entity does not need to provide records in a requested electronic format if: Such format is not reasonably available without additional cost to the entity. If the records would be subject to modification in the format requested; or if the entity determines that the integrity of the records could be compromised in the format requested.

*****PLEASE NOTE, our office is unable to provide records returned via the email system due to the HITECH ACT. It is our office policy that you are only able to pick them up and/or have them mailed to the address on file. The fee for the records must be paid in advance before records will be provided.***

Any and all requests for access to health records must be made in writing via mail to:

19441 Golf Vista Plaza, Suite 230, Attention: Medical Records, Lansdowne, VA 20176 or to the email assigned – CSCCMedicalrecords@lmgdoctors.com.

The request must be dated, signed by the requestor; you must also provide your full name, date of birth, last 4 of Social Security Number and provide your mailing address (This must match what we have on file for you). There is a form available for you to complete and can and will be provided upon request to notify us as to the nature of the information requested, include evidence of the requestor's authority to receive access, identify the person to whom information is to be disclosed, and specify the preferred format.

Within (15) days of receiving a request for access, the entity must take one of the following actions: Furnish the copies of or allow access to the requested records in electronic format, if requested; If the information does not exist or cannot be found, inform the requestor; If the entity does not maintain a record of the information, inform the requestor and provide the name and address of the entity that does maintain the record, if known; or deny the request.

CONSENT FOR SPOUSES OR PERSON WE CAN SHARE YOUR HEALTH PROTECTED INFORMATION WITH:

We understand the importance of being able to communicate or share certain pieces of health related information to your family members or spouses. The HIPPA Privacy Act requires that must obtain permission from you before we can share any health related information which includes: Appointments, Insurance/Account billing, and treatment related information as well. If you would like for us to be able to share certain pieces of this information, please make sure you list their names below and designate their relationship to you and check the boxes applicable. **YOU MAY OPT OUT OF THIS CONSENT BY PROVIDING WRITTEN NOTIFICATION.**

1. _____ (first and last name required) _____/_____/_____ (DOB-required)

Relationship ❑ spouse ❑ family member _____❑ guardian ❑ Payment/Ins Info ❑ Medical Info ❑ Appointments

2. _____ (first and last name required) _____/_____/_____ (DOB-required)

Relationship ❑ spouse ❑ family member _____❑ guardian ❑ Payment/Ins Info ❑ Medical Info ❑ Appointments

3. _____ (first and last name required) _____/_____/_____ (DOB-required)

Relationship ❑ spouse ❑ family member _____❑ guardian ❑ Payment/Ins Info ❑ Medical Info ❑ Appointments

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❑ **I DO NOT WANT MY INFORMATION SHARED WITH ANYONE**

CONSENT FOR VIDEO TAPINGS

As part of a diagnostic sleep study, video surveillance may be required. All information and data will be kept confidential.

I, _____,hereby authorize the use of video surveillance for the purpose of medical diagnosis. If the patient being tested is a minor (under 18 years of age), he/she must be accompanied by a guardian for the entire test.

Patient / Guardian Signature: _____Date: _____/_____/_____

VOICEMAIL | EMAIL | SMS TEXT OPT-IN AGREEMENT

Our office understands that you may be very busy when it comes to being reminded about appointment(s) with your providers, our office has a system in place so that we can notify you of any appointment that is scheduled and you can receive these reminders via **TEXT or VOICEMAIL**. ****Please indicate below if you would like to Opt-In or Out for these service(s).**

Please note- that you are able to Opt Out anytime for all automated calls / texts, you will still receive Live calls reminding you of the appointments unless you indicate DO NOT CALL.

A. VOICE MAIL OPTIONS: An automated call is made to your either your home, office or cell phone in which you can designate the location to be called and the preferred language chosen can be (English/Spanish), you can also designate when you would like to have these calls sent to you for either (morning/afternoon/evening). Please read and check all applicable. YOU ARE STILL REQUIRED TO FOLLOW THE CANCELLATION POLICY. Voice and Text Options have to be the same for the Language/Time Set; must be one or the other cannot be different.

❑ Opt-In Voice Call to: ❑ Home ❑ Office ❑ Cell **(please follow the prompts provided to confirm these appointments)**
❑ English ❑ Spanish ❑ Morning ❑ Afternoon ❑ Evening ❑ **I DO NOT WANT TO RECEIVE AUTOMATED VOICE REMINDERS.**

B. SMS TEXT OPTIONS: A text is made to your cell phone provided, you can designate the preferred language (English/Spanish), you can also designate the time your texts are sent to you. Additional rates may apply from your carrier for this feature.

❑ Opt-In ❑ Cell Text **(please follow the prompts provided to confirm these appointments)** ❑ English ❑ Spanish ❑ Morning
❑ Afternoon ❑ Evening ❑ **I DO NOT WANT TO RECEIVE AUTOMATED TEXT REMINDERS.**

C. EMAIL NOTIFICATIONS: Our office will need to reach out to you via email from time to time if we have not been able to reach you to confirm an appointment or if we need to provide you any inner office communication for your medical purposes only. We do not use your email for solicitation services and you can Opt-Out of any notices being provided to you as well.

❑ Opt-In ❑ **I DO NOT WANT TO RECEIVE EMAIL NOTIFICATIONS**

Patient / Guardian Signature: _____Date: _____/_____/_____

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NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

LMG is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any LMG health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under VA Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a LMG health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I understand that this consent will remain in effect as long as my dependent or I receive care from LMG or until I withdraw it.

Print Name: _____ Date: _____/_____/_____ Signature: _____

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

Patient Name: _____Date of Birth: _____/_____/_____SSN: _____ (last 4 only)

Address: _____City: _____State: _____ Zip:_____

Phone Home: _____-_____-_____Phone Cell: _____-_____-_____

I authorize the custodian of records, or other person/entity (specifically describe) to disclose/release the following information:* (check all applicable)

❑ All Records ❑ Billing Records ❑ Sleep Study Data / Report / Video ❑ Progress Notes ❑ Pharmacy / Prescription Records

❑ Other (describe specifically): _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____/_____/_____ thru _____/_____/_____

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GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION-"CONTINUED"

Please send the records listed above to: (use additional sheets if necessary)

Name: _____
Address: _____
City: _____State: _____Zip: _____
Phone: (_____) _____- _____
Fax: (_____) _____- _____

Name: _____
Address: _____
City: _____State: _____Zip: _____
Phone: (_____) _____- _____
Fax: (_____) _____- _____

This authorization shall expire not later than: _____/_____/_____ or (whichever is sooner), and may not be valid for greater than one year from the date of signature for Virginia medical records.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law but it may permit me from being able to retrieve records on my behalf from other providers.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____
Signature of Patient: (or Patient's Personal Representative)

_____
Representative's for patient: (i.e. – parent, guardian)

_____
Printed Name of Patient Representative:

_____/_____/_____
Date

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LOUDOUN MEDICAL GROUP
Receipt of Notice of HIPAA Privacy Practices Acknowledgement

_____
Patient's Name

I have a received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

_____
Signature

Date: _____

_____
Relationship to Patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**

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LOUDOUN MEDICAL GROUP PC
NOTICE OF HIPAA PATIENT 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.

If you have any questions or comments about this Notice please contact:

Loudoun Medical Group, PC
224-D Cornwall St. N.W., Suite 403
Leesburg, VA 20176

Our Privacy Officer is: Clara McAuley Nussbaum, Director of Compliance, 703-737-6010

The following is the privacy policy ("Privacy Policy") of **Loudoun Medical Group, PC d/b/a Comprehensive Sleep Care Center** ("Covered "Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Who Does this Notice Apply to?

Loudoun Medical Group, PC ("LMG"), has published this Notice. It applies to everyone who works for Loudoun Medical Group, PC, including our employees, contractors, and volunteers.

Why Do We Publish this Notice?

LMG understands that information about you and your health is sensitive and personal. We are required by law to maintain the privacy of information we gather and use about our patients, and provide them with notices of our legal duties and privacy practices with respect to their information. We are also required to notify affected individuals of any breach of unsecured protected health information.

While we are committed to the privacy of our patients' information, in order to serve them we need to gather, keep and use records of this information. We sometimes also need to share information with other parties. This Notice is intended to let you know how we use and disclose your information.

This Notice is also to let you know about certain legal rights you have with respect to the information we hold about you. You have certain rights to review and obtain a copy of our records of information about you. You may also request that we amend these records, and may ask us to account for certain disclosures we may have made of information about you. Requests for amendments and requests for accountings must be made in writing and directed to the Privacy Officer.

When Is This Notice Effective?

We are required to comply with the terms of this Notice while it is in effect. We reserve the right to change the terms of this Notice, and make the new terms effective for all information to which this Notice applies. This Notice will be in effect from **May 20, 2013** until the date we publish an amended Notice. If we do publish an amended Notice, we will notify you at your next visit. We will also publish the amended Notice in our offices, and will publish it on our web site if we maintain one.

What Information Does this Notice Cover?

This Notice covers all information in our written or electronic records which concerns you, your health care, and payment for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

When Can We Use or Disclose Information About You?

- ***Treatment***. We may use or disclose information about you for treatment purposes to doctors, nurses, technicians, medical students or other individuals who work in our practice who are involved in providing you with health care. We may also disclose information about you to organizations and individuals involved in your care who are outside of our practice, such as consulting physicians, laboratories, social workers, and so on.

  For example, if we refer you to another physician or a hospital for specialty services, we will provide that physician or hospital with all clinical information, which might be necessary or helpful to help them provide you with the right care. Or, if we need to send a sample of your

blood to a laboratory for analysis, we will provide the laboratory with the information they need to process your blood correctly.
These are only examples, and we may use or disclose information about you to provide you proper treatment in many other ways.

- ***Payment***. We may use or disclose information about you for payment purposes to our clerks and officers involved in billing and claims payment. We may also disclose such information to your health plan or other party financially responsible for your care, or to claims and billing services if necessary.

  For example, if you are covered by a health plan we cannot get paid for the services we provide you unless we submit information in a claim. This might include detailed clinical information, depending on the kind of plan and claim. This is only an example, and there may be many other ways in which we may use or disclose information about you in connection with payment for your care.

- ***Health care operations***. We may use or disclose information about you for operations in connection with our practice. These activities might include practice quality improvement, training of medical students, insurance underwriting, medical or legal review, and business planning or administration of our practice.

  For example, we may wish to review the quality of care you receive, in order to help us deliver the best care we can. Or, we may audit our management practices so we can become more efficient. These are only examples, and we may use or disclose information about you for health care operations in many other ways.

We may also use and disclose information about you in the following situations, without your prior authorization:

- To a public health agency, for purposes such as controlling disease.
- In case of suspected child abuse, to the appropriate governmental authority.
- In other cases of suspected abuse, neglect or domestic violence, to the appropriate governmental authority, with your agreement or if required by law, or if you are incapacitated or it appears necessary to prevent serious harm to you or others.
- Unless you object, to friends or family members who are involved in your medical care.
- Unless you object, to notify, or to assist in notifying, a family member or friend of your location or condition.
- To health oversight authorities, for regulatory, licensing and other legal purposes.
- In litigation and legal proceedings, subject to certain requirements controlling the terms of the disclosure.
- To law enforcement agencies, subject to applicable legal requirements and limitations.
- We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
- To Funeral Directors/Medical Examiners/Coroners in the event of your death.
- When required by Federal, State or Local law.
- For medical research purposes, subject to your authorization or approval by an institutional review board or privacy board.
- If you are in the United States military, national security or intelligence, Foreign Service, to your authorized superiors or other authorized federal officials.

We may contact you for information to support your health care, including appointment reminders, information about alternative treatments, and health-related services, which may be of interest to you. We will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appoint-ments. *Please advise us if you do not wish to receive such communications*, and we will not use or disclose your information for such purposes. If you wish not to receive this kind of communication, you must advise the Privacy Officer in writing at the address given above.

Most uses and disclosures of psychotherapy notes and most uses and disclosures of your information for marketing purposes will require your written authorization. Further, LMG would typically be required to obtain your written authorization in order to sell your information. Except for uses and disclosures described in this notice, we may not use or disclose information about you for any other purpose without your written authorization.

What Legal Rights Do You Have In Connection With Your Information?

- Right to Inspect and Copy. You have the right to inspect or obtain copies of your medical information. To inspect and copy medical information, you must submit your request in writing to the Privacy Officer at the address set forth above. If you request a copy of the

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4897 Prince William Parkway, Suite 102, Woodbridge, VA 22192 • 3687 Fettler Park Drive, Dumfries, VA 22025
12321 Middlebrook Road, Germantown, MD 20874 • 8100 Ashton Ave., Suite 216 Manassas, VA 20109•
6000 Executive Blvd, Suite 604, North Bethesda, MD 20852
Phone: 703 -729-3420 Fax: 703-729-3422 • www.ComprehensiveSleepCare.com

information, there will be a charge based on our costs.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional. We will comply with the outcome of the review.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information.

  To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address set forth above. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for LMG;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

  You will be informed of the decision regarding any request for amendment of your medical information and, if we deny your request for amendment, we will provide you with information regarding your right to respond to that decision.

- Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your medical information. The accounting of disclosures typically would not list disclosures we made of medical information about you that were made for purposes of treatment, payment, or health care operations and that were made in response to a specific authorization from you.

  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address set forth above. Your request must state a time period for which you want the accounting (which may not be longer than six years prior to the request).

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to a requested restriction, unless (i) you are requesting that we not disclose information to a health plan for payment or health care operations of the health plan, and (ii) the information pertains solely to an item or service for which you or someone other than the health plan has already paid in full. If we do agree to a requested restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Additionally, even when we do not agree to a requested restriction, health information about you may only be disclosed to family or friends if, in the exercise of professional judgment, we believe it is in your best interest to have such information disclosed. However, under such circumstances, where practical, you will be given the opportunity to object to any such disclosure.

  To request restrictions, you must make your request in writing to the Privacy Officer at the address set forth above.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the Privacy Officer at the address set forth above. Your request must specify how or where you wish to be contacted.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- Complaints. If you believe your privacy rights have been violated, you may file a complaint with LMG or with the Secretary of the Department of Health and Human Services. To file a complaint with LMG, contact the Privacy Officer at the phone number or address set forth above. All complaints to the Department of Health and Human Services must be submitted in writing. We will not retaliate against you for filing a complaint.

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Child Full Name:		Child DOB: _____/_____/_____	Today's Date: _____/_____/_____

1. What is the child's height? _____

2. What is your child's weight? _____

3. Please tell us the main reason for your child's office visit or test with us:

❑ Snoring ❑ Excessive daytime sleepiness ❑ Leg movements during sleep ❑ Difficulty falling/staying asleep

❑ Poor sleep-wake schedule ❑ Disruptive behaviors during sleep ❑ Other: _____

4. When did your child sleep problem start? _____

5. Has your child been diagnosed hyperactive? ❑ YES ❑ NO

6. Do you know, or have you been told that your child snores? ❑ YES ❑ NO

7. Has your child ever had an overnight sleep study (Polysomnogram)? ❑ YES ❑ NO

If yes, when and what did the results show? _____

8. What is your child bedtime? _____

9. Does your child have trouble falling or staying asleep? _____

10. How many times does child usually awaken during the night? _____

11. How many hours does your child get to sleep at night? _____

12. Any history of tonsillectomy and adenoidectomy? _____

13. Any history of strep throat and ear infection? _____

14. SNORING & SLEEP APNEA

Does your child snore loudly or gasp or choke at night? ❑ YES ❑ NO

Does your child often awaken with a dry mouth/sore throat/morning headaches ❑ YES ❑ NO

Does your child sleep walk? ❑ YES ❑ NO

Does your child have night terror? ❑ YES ❑ NO

15. EPWORTH SLEEPINESS QUESTIONNAIRE

In the table below, please indicate how easily your child doses off to sleep in the following situations:

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	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or 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 a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

16. MOVEMENTS DURING SLEEP

Does your child ever experience twitching or jerking of your legs while asleep? ❑ YES ❑ NO

Does your child have any uncomfortable sensations (e.g. insects crawling) in legs that makes it difficult to fall asleep? ❑ YES ❑ NO

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Does your child ever feel an inner urge to move or "reposition" legs while sitting or lying still? ❑ YES ❑ NO

Does your child have any discomfort in legs at night? ❑ YES ❑ NO

17. OTHER SLEEP SYMPTOMS

When falling asleep or waking up, has your child experienced of seeing things or hearing things that weren't really there? ❑ YES ❑ NO

When falling asleep or waking up, has your child ever experienced very brief periods of being unable to move your arms or legs even though you tried? ❑ YES ❑ NO

18. MEDICATION (OPTIONAL, IF YOU HAVE TIME)

Please list all prescription and over-the-counter medications that your child currently uses:

Name	Dosage	Frequency	Reason for Medication

_____ Date: _____/_____/_____

Patient / Guardian Signature

VERY IMPORTANT INFORMATION TO READ PRIOR TO SLEEP STUDY PREPARATION

A fee of $150 will be charged for cancellations or changes within 72 hours of an appointment

Please be aware of the location and suite you are scheduled for, and note the instructions for entry into the facility:

If you are scheduled for a sleep study and cannot enter the building please press 1 and select one of the following: press 1 for Woodbridge, press 2 for Arlington, press 3 for Lansdowne, press 4 for Chantilly, press 5 for Dumfries, press 6 for Manassas and dial direct for Germantown (240) 238.2186, and dial direct for BETHESDA (703) 293-5241.

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*****SHOULD YOU HAVE AN ISSUE WITH ENTRY INTO ANY OF OUR CENTERS, PLEASE CALL (571) 439-9848*****

LANSDOWNE:	19441 Golf Vista Plaza, Suite 230, Lansdowne, VA 20176 **Press 14491 on the keypad to enter the building.**
CHANTILLY:	14141 Robert Paris Court, Chantilly, VA 20151 **Proceed to the rear of the building to park. Directly enter the unit without access restriction**
ARLINGTON:	200 N. Glebe Road, Suite 316, Arlington VA 22203 **Proceed to the rear of the building to park. Press the # key associated with the Sleep Center on the directory. Await the release of the door, and proceed to wait at the front of the elevator, where a technician will arrive to escort you into the facility.**
DUMFRIES:	3687 Fettler Park Drive, Dumfries, VA 22025 **Proceed directly to enter the unit without access restriction**
WOODBRIDGE:	4897 Prince William Parkway, Suite 102, Woodbridge, VA 22192 **Please use your cell phone to call (703) 729-3420, and press 1 for one of our staff**
MANASSAS:	8100 Ashton Avenue, Suite 216 Manassas, VA 20109 **Please use your cell phone to call (703) 729-3420, and press 6 for one of our staff**
GERMANTOWN:	12321 Middlebrook Rd, Germantown, MD 20874 **Please use your cell phone to call (240) 238-2186**
BETHESDA:	6000 Executive Blvd, Suite 604, North Bethesda, MD 20852 **Proceed to the front of the building to park. Call Datawatch outside the building by pressing the button at the front pedestal that houses ADA push pad. This is located directly to the right of the front door. A Datawatch representative will answer and request for entry code. Your entry code is "000620176". Datawatch will then release the front door, and you should proceed to the elevators and call the elevator to the sixth floor. If you need to speak technician on duty please use your cell phone to call (703) 293.5241 and press 1 for one of our staff.**

❑ Arrive to your designated sleep lab at your appointment time. **Pediatric patients are welcome to arrive at 8:30 pm.**

❑ Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply makeup, nail polish, face or body cream/lotion, as they may interfere with electric sensors.

❑ Take all your regular medications, unless instructed by your physician to do otherwise. Keep a record of your medications and the time taken. Please bring any medication that you may need to use during your stay.

❑ Please do NOT consume beverages or food containing caffeine after 12:00 p.m. on the day of the study.

❑ Try to get a full night of sleep the night prior to your study. Please do NOT take any naps the day of your study.

❑ Please bring nightclothes for the study. Loose fitting, cotton pajamas are preferred. Please avoid nightclothes that are made of satin, nylon, or silk because the chemicals/pastes could damage them.

❑ Feel free to bring personal belongings to your study that may help your sleep more comfortably, e.g., favorite pillow, blanket, book, etc.

❑ Bathrooms with shower stalls are available for your convenience at Arlington, Chantilly, Dumfries, Germantown and Lansdowne. You may choose to bring a tooth brush, toothpaste, shampoo and soap for the morning to freshen up. In addition, you may have to wash your hair several times to remove the paste from your hair used during the study.

❑ You are usually free to leave by 6:00-6:15 am.

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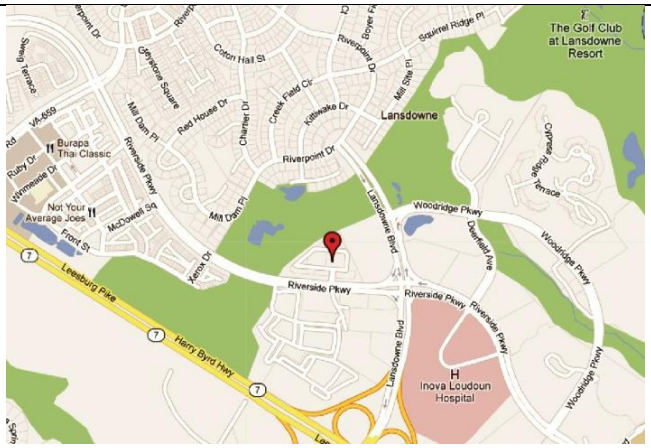
SPECIAL INSTRUCTIONS FOR MULTIPLE SLEEP LATENCY (MSLT) TEST

1. The MSLT is usually performed the morning after an all night sleep study.
2. Continental breakfast and catered lunch are provided for this test.
3. Please bring reading materials to read during your stay with us.
4. The testing is usually concluded between 4:00-5:00 pm.

ADDITIONAL QUESTIONS IN PREPARATION FOR YOUR SLEEP STUDY – PLEASE CONTACT US AT 703-729-3420.

LANSDOWNE CENTER: 19441 Golf Vista Plaza, Suite 230, Lansdowne, VA 20176

Route 7 West:	• Take VA-7 West toward Leesburg/Winchester • Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne • Turn left onto Riverside Parkway • Turn Right onto Golf Vista Plaza
Route 7 East:	• Take VA-7 East toward Tyson's Corner • Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne • Turn left onto Riverside Parkway • Turn Right onto Golf Vista Plaza
Route 28:	• Take VA-28 North toward VA-7 West toward Leesburg/Winchester • Exit onto Lansdowne Blvd. toward VA 2400 N/Lansdowne • Turn left onto Riverside Parkway • Turn Right onto Golf Vista Plaza



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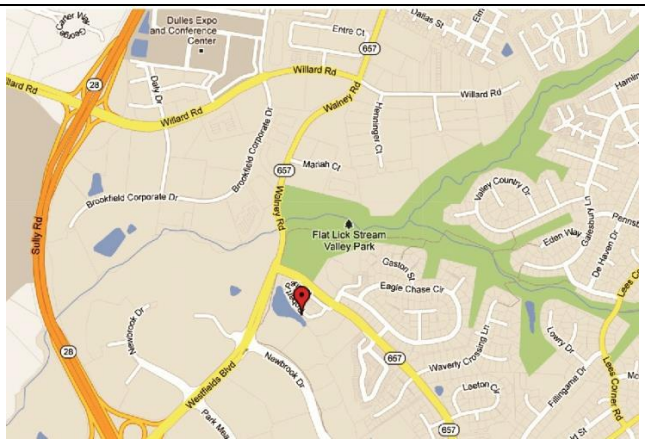
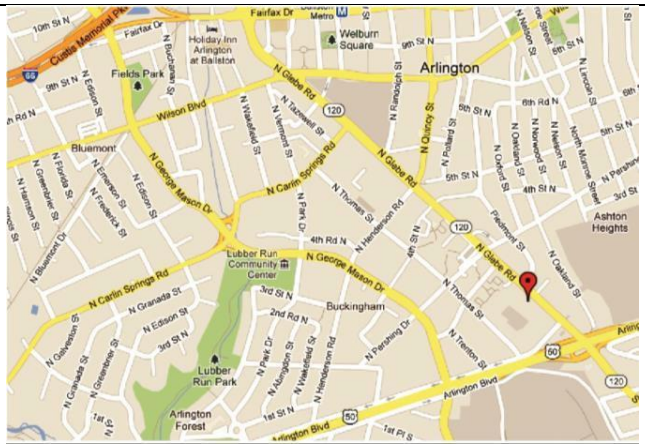
CHANTILLY CENTER: 14141 Robert Paris Court, Chantilly, VA 20151

Route 66 West:	• Take Route 66 West to Exit 53B VA-28 North • Keep right at fork and Merge onto VA-28 North/Sully Road • Take the Westfields Blvd exit toward County Road 662 • Keep right at fork and merge onto Westfields Blvd • Turn right onto Walney Road • Turn right onto Robert Paris Court	
Route 50 West:	• From Route 50 West • Turn left onto Walney Road • Turn left to stay on Walney Road • Turn right onto Robert Paris Court	
Route 50 East:	• From Route 50 East • Turn right onto Walney Road • Turn left to stay on Walney Road • Turn right onto Robert Paris Court	

ARLINGTON CENTER: 200 N. Glebe Road, Suite 316, Arlington, VA 22203

Route 66 West:	• Take Route 66 West • Exit 71 onto VA-120 Glebe • Road Turn left onto N. Glebe Road	
Route 66 West:	• Take Route 66 East • Exit 71 for Fairfax Drive toward VA-120/VA-237/Glebe Road Merge onto N. Fairfax Drive • Turn right onto N. Glebe Road	
Route 50 West:	• Take Route 50/Arlington Blvd. East to Glebe Road exit • Turn Left at the traffic light onto N. Glebe Road Building is on the Left hand side	
Route 50 East:	• Take Route 50/Arlington Blvd. West to Glebe Road exit • Turn Right at the traffic light onto N. Glebe Road Building is on the Left hand side	

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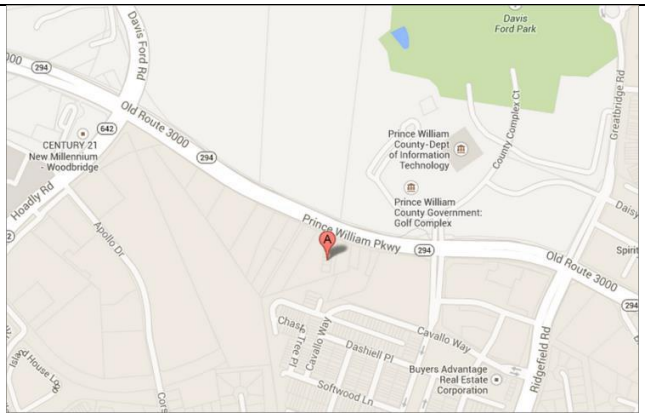
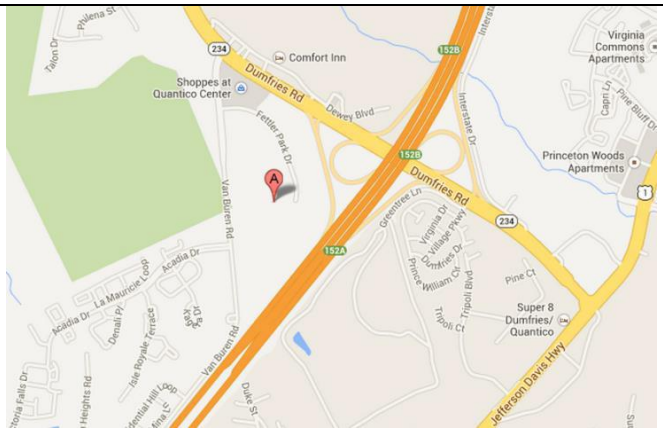
WOODBRIDGE CENTER: 4897 Prince Wm Pkwy, Ste. 102, Woodbridge, VA 22192

From 95	• Merge onto 95 North • Take Exit 152-B towards Manassas to merge onto VA-234 N • Dumfries Rd towards Manassas – and go 4.0 miles • Follow Spriggs Rd and State Rte 642/ Hoadley Rd to Prince William Pkwy in Dale City – about 7.3 miles. • Turn right onto Spriggs Rd and go 4.5 miles, • Turn right onto State Rte. 642/Hoadly Rd and go 2.5 miles. • Turn right onto Prince William Pkwy – Destination will be on the right • Make a U-turn onto Hoadly Road/VA-642 E and go 0.1 miles Take the 1st right onto Prince Wm Pkwy/VA-294 S and go 0.3 miles • If you reach County Complex Ct – You've gone about 0.1 miles too far.
From 95 N	• Merge onto 95 • South Take Exit 163 for VA-642 towards Lorton • Turn right onto VA-642/Lorton Rd for 1.3 miles, slight left onto Lorton Rd, go 0.7 miles • Turn left onto Ox Rd and go for 1.1 miles Continue onto VA-123 S/Gordon Blvd Turn right onto Old Bridge Rd. • Continue onto VA-294 W/Prince • William Pkwy for 1.2 miles, Make a U-turn, destination will be on right.



DUMFRIES CENTER: 3687 Fettler Park Drive, Dumfries, VA 22025

From 95	• Merge onto 95 North or South (if coming from Springfield) • Take Exit 152 B to merge onto VA-234 N toward Manassas • Turn left onto Van Buren Rd. and go 0.2 miles Turn left onto Fettler Park Dr, Destination will be on the right
From 95 N	• Merge onto 1-95 N towards Washington, DC • Take Exit 152-B and merge onto Dumfries Rd, VA-234 N towards • Manassas



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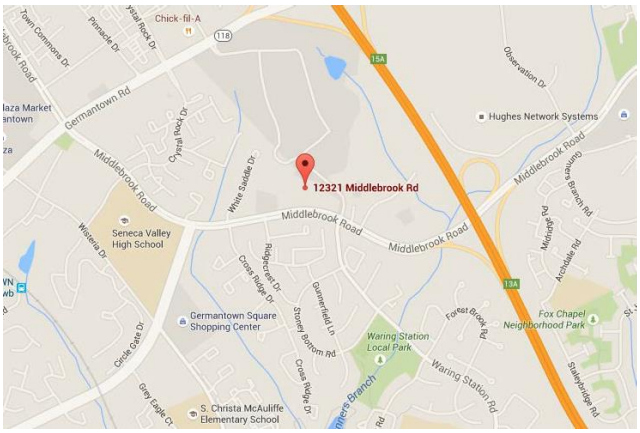
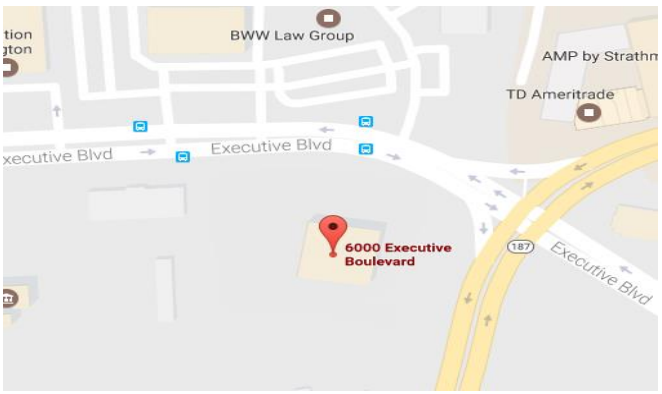
GERMANTOWN: 12321 Middlebrook Road, Germantown, MD 20874

From 95	• Take I-895 S, I-95 S, MD-200 W and I-270 N to Middlebrook Road in Germantown. • Take exit 13B from I-270 N Merge onto Middlebrook Road	
From 95 N	• Take I-95 N and I-495 N to Middlebrook Road in Germantown. Take exit 13B from I-270 N • Merge onto Middlebrook Road	

MANASSAS: 8100 Ashton Ave., Suite 216 Manassas, VA 20109

From areas below Manassas	• 66 E ramp to Washington 0.9 mi, Merge onto I-66 E 3.5 mi • Take exit 47 for VA-234 N/VA-234 toward Manassas 0.1 mi • Slight right onto VA-234 BUS S/Sudley Rd (signs for Virginia 234/Manassas) 0.9 mi • Turn right onto Sudley Manor Dr 0.4 mi • Turn left onto Ashton Ave • Destination will be on the right	

NORTH BETHESDA: 6000 Executive Blvd, Suite 604, North Bethesda, MD 20852

From areas below N. Bethesda	• Head northwest on I-495 W for 0.9 mile • Keep right at the fork to continue on I-270 N, follow signs for Frederick for 1.4 mile. • Take exit 1A for MD-187/Old Georgetown Rd 0.1 mile • Keep right at the fork, follow signs for Old Georgetown Rd N/MD-187 N and merge onto MD-187 N/Old Georgetown Rd. • Turn left onto Executive Blvd • Turn left. The destination will be on the right.	

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SLEEP STUDY FAQ'S

1. What is a sleep study?

A sleep study is a non-invasive test where your brain waves and sleep patterns are monitored by a trained sleep technician. While you sleep, we collect data that will help us understand your sleep better. Based on the results, a personalized treatment plan is developed by or board-certified sleep physicians and your follow-up appointment with our sleep specialist or your referring physician will be the next step.

2. What is involved in a sleep study?

A sleep study is completely painless. Sticky patches called sensors are placed on your scalp, face, chest, limbs and a finger. While you sleep, these devices record your brain activity, eye movements, heart rate and rhythm, blood pressure, and the amount of oxygen in your blood. Elastic belts are placed around your chest and abdomen. They measure chest movements and the strength and duration of each exhaled breath. The wires will be attached to sensors that transmit data to a computer in the next room. The wires are very thin and flexible and are bundled together to minimize discomfort. You will be able to roll in any direction. Although we call the procedure of attaching these items the "hook-up" process, there are no hooks involved and no needles. The hook- up is not painful and is designed to be as comfortable as possible. Many people ask us how they will be able to sleep while connected to these sensors and belts. Most people find that once they lie down in bed, they do not notice the wires and can sleep in a variety of positions comfortably. The sensors are gathered into a "pony tail" above your head so that you can change position in bed almost as easily as you would at home. The technician will explain all the procedures and will be happy to answer your questions about the study.

3. Are sleep studies safe and are they comfortable?

Yes, sleep studies are safe. We simply monitor your brain and muscle activity, sleeping position, and breathing while you are sleeping. There are no needles, drugs or other invasive procedures. Well-trained sleep technologists will monitor your entire sleep-testing period from a nearby room. As for the comfort level, we do our best to make your stay comfortable. However it may feel a bit awkward. You will stay in a private, comfortable, home-like bedroom with plush bedding. You can wear your usual bed clothes and you may bring your own pillow if you prefer. You can read at bedtime or watch TV. For many, our private, comfortable, home-like setting is preferred over a hospital environment.

4. Why do I have to stay overnight?

Overnight sleep studies are the "gold standard" used for accurately diagnosing sleep disorders. Overnight studies are necessary in part because sleep patterns may vary throughout the night. In addition, overnight studies are important for detecting more subtle symptoms

5. If I work the night shift can I come in during the day?

Yes. Ideally the sleep study will occur during your normal sleeping time.

6. What time do I need to be at the center for my sleep study?

For our adult patients we ask that you when you schedule your exam you schedule it based on two arrival time slots, the first one is to arrive at 9 pm, and the second slot is at 9:45 pm. This is to ensure our technologists can assist you in your needs and setup with ample in a relaxed manner as it takes some time for you to settle in. **Pediatric patients are welcome to arrive at 8:30 pm.**