

# Sleep and breathe specialists REGISTRATION FORM



## PATIENT INFORMATION

Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Former/Legal name: / /		Birth date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.: (Can give at office if you prefer)		Cell phone no.: ( )		
Home Phone no.: ( )		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ( )		
Referred by:  _____							
Other Medical Provider you want a copy of your notes sent to:					Fax number:		
Other family members seen here:							

## INSURANCE INFORMATION

(Please also give your insurance card and drivers license to the receptionist.)

Person responsible for bill:		Birth date: / /	Address (if different): <input type="checkbox"/> same address as above		Home phone no.: ( )		
Occupation:	Employer:	Employer address:			Employer phone no.: ( )		
Insurance company:		Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____					
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other							

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or my insurance company to release any information required to process my claims. I understand that if my insurance (notably Humana, some other HMO plans) denies the visit because I do not have the appropriate referral then I will be responsible for the charges incurred. If you are unsure if you need a referral ask your primary care provider to fax one to 801-931-2307.

\_\_\_\_\_  
Patient/Guardian signature

\_\_\_\_\_  
Date

Sleep and Breathe Specialists  
4063 W 12600 S #SABS  
Inside the ENT Center of Utah  
Riverton, UT 84096  
Phone: 801-935-8180 (Call or Text)  
Fax: 801-931-2307



**By signing below, I affirm I have reviewed and been given a copy (if desired) of the following forms and policies.**

### **Patient Rights and Responsibilities Form**

#### **Privacy Policy**

**Insurance Billing Policy:** I understand that copays are due at the time of service and that there will be a 50 dollar (50\$) cancellation fee for missed appointments (waived if you call the day before or if you call with a significant emergency--we understand life happens! If there is no call and it is marked as a no-show then this policy may apply). I also understand that if my insurance does not cover the provided services I will be asked to pay the customary charges.

**I give permission for Dr. Bird's Office to digitally obtain copies of my medications as well as send my medication prescriptions electronically.**

**I give permission for Dr. Bird's Office to send me e-mail, phone, or text reminders for appointments. They will not include my personal information but are not secure.**

#### **Cancellation Policy**

**Please initial that I, \_\_\_\_\_, am aware Dr. Bird's Office can charge a \$50 charge for any appointments that are not cancelled before 24 hours of scheduled appointment. \_\_\_\_\_**

#### **Optional Agent Designation:**

**I give permission for \_\_\_\_\_ to discuss my health care, make appointments or have copies of my records at any time.**

### **Patient Information**

Patient Name:

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Patient  
Signature:

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Date:

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# OUR PRIVACY POLICY



As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance portability and Accessibility Act (HIPPA),

Sleep and Breathe Specialists can use your protected health information for treatment, payment and health care operations.

1. Treatment – we may use or disclose your health information to a physician or other health care provider providing treatment to you.
2. Payment – we may use and disclose your health information to obtain payment for services we provide you.
3. Healthcare Operations – we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require your written authorization. Upon signing, you may revoke your authorization in writing through our practice at anytime.

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or other person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement with your healthcare.

We will not use your health information for marketing communications without your written consent. We may also use or disclose your health information when we are required to do so by law. With your permission we will contact sure scripts (an online medication repository) and obtain your current medications from that source.

With your permission we will send e-mail and text reminders. Please remember that (unless initiated from within a secure site) e-mails and texts are NOT secure. Please do not transmit any personal information to us via text or e-mail as there is no way to prevent access to that information. We will avoid sending more than: date of appointment, non-specific answers to general questions ("can you please call me at 321-888-9999" to which we can reply "yes" or "in a few minutes") and responses which do not contain protected health information. We want to provide rapid access to our clinic but want to protect your health information as well. If you wish to connect to us securely please do that through our portal. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health and safety.

We may disclose the health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

You have the right to restrict the disclosure of your protected health information in writing. The request for restriction maybe denied if the information is required for treatment, payment or healthcare operations.

You have the right to

- Receive confidential communications regarding your protected health information.
- Inspect a copy of your protected health information.
- Amend your protected health information.
- Receive an account of disclosures of your protected health information.
- A paper copy of this notice of privacy practices.

If you have any complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

For further information about Sleep and Breathe Specialists' privacy policies, please contact our office and at the following address or phone number.

4063 W 12600 S #SABS

Inside the ENT Center of Utah

Riverton, UT 84096 Phone: 801-935-8180 [www.garrettbird.com](http://www.garrettbird.com)

## Sleep and Breathe Specialists Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

### ***You have the right to:***

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

### ***You are responsible for:***

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

