

ROBERT N. WOLFE, M.D. ANDREW S. WACHTEL, M.D. ROY ARTAL, M.D.
TOWER SLEEP MEDICINE
8635 West Third Street, Suite 965
Los Angeles, CA 90048
310-657-3792

GENERAL CONSENT FOR CARE AND TREATMENT

The practitioners at **Wolfe, Wachtel and Artal/Tower Sleep Medicine (WWA)** are committed to protecting and preserving your rights. As a patient, you have the right to be informed about your medical condition and the diagnostic and/or therapeutic procedures recommended by the WWA practitioner(s) in order to make informed decisions about your health care. For purposes of this consent, practitioner includes a WWA physician, physician extender (*e.g.*, nurse practitioner), polysomnographic technologist, and/or clinical nurse specialist.

No specific diagnosis or treatment plan has been identified or recommended at this point in your care. By signing below, you are consenting to the performance by your WWA practitioner(s) of medical services which are necessary and routinely furnished in the office of an internal medicine, pulmonary medicine and/or sleep medicine group, such as pulmonary function, home sleep apnea and allergy testing, and routine treatments for the condition that brought you to WWA for medical care, such as injections of vaccines/antibiotics and administrations of inhaled medications. Importantly, you would be asked to provide additional written consent(s) if your WWA practitioner recommends non-routine diagnostic examinations and/or testing, or non-routine treatment procedures.

By signing below, you are also (1) acknowledging your right to ask questions of your WWA practitioner(s), (2) confirming your intention that this consent will be continuing in nature even after your WWA practitioner(s) makes a diagnosis and recommends treatment, (3) confirming that this consent will remain in effect until revoked by you in writing, (4) certifying that you have read and understand the contents hereof, and (5) certifying that you are voluntarily signing this consent.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE CAREFULLY REVIEW THIS NOTICE!

EFFECTIVE DATE: SEPTEMBER 23, 2013

Robert N. Wolfe, M.D., Andrew S. Wachtel, M.D., and Roy Artal, M.D. furnish medical and related services to patients through a partnership (**WWA**) of professional corporations. WWA sometimes operates under the name **Tower Sleep Medicine**. WWA understands that information about your health is very personal. WWA strives to protect the privacy and security of individually (patient) identifiable health information (**PHI**) that it receives, creates, or maintains in accordance with applicable law. WWA educates its workforce to respect patient privacy and to comply with the laws applicable to the confidentiality and security of PHI.

This Notice summarizes your rights with regard to your PHI. This Notice also summarizes the obligations of WWA with regard to your PHI. WWA is required to abide by the terms of this *Notice of Privacy Practices* for so long as they remain in effect. WWA reserves the right to change the terms of this *Notice of Privacy Practices* as and to the extent necessary and to make such new practices effective as to any and all PHI then in its possession. You may ask for a copy of the current *Notice of Privacy Practices* at the office. You may also send a written request by mail to **Wolfe, Wachtel & Artal, 8635 West Third Street, Suite 965, Los Angeles, CA 90048**.

The terms of this *Notice of Privacy Practices* apply to the following individuals and entities:

- WWA affiliated physicians
- WWA employees, including paramedical and non-professional staff, who reasonably require access to PHI in connection with the performance of their job functions
- Independent entities and individuals, also known as “**business associates**,” who reasonably require access to PHI in connection with the performance of their functions and activities in support of WWA operations (e.g., billing and transcription)
- A member of an authorized volunteer group who may require access to PHI in connection with your receipt of health care services

USES AND DISCLOSURES OF YOUR PHI

The following categories detail the various ways in which WWA may use or disclose your PHI. WWA may provide examples for each category of uses or disclosures. Please note that not every use or disclosure will be listed below. However, each way in which WWA may use or disclose your PHI will fall into one of the following categories:

1. **Signed Authorization.** In specific situations, WWA will not use or disclose your PHI without you signing an authorization form. The authorization form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke authorization in writing, except to the extent WWA already relied upon it. These situations include:
 - Uses and disclosures of alcohol and drug abuse/dependency records, HIV-related information, and psychotherapy notes
 - Uses and disclosures of PHI for marketing purposes, including marketing communications paid for by third parties, and
 - Disclosures which constitute sales of PHI

WWA will not use or disclose your PHI without a signed authorization from you except and to the extent as outlined below.

2. **Treatment.** WWA may use your PHI in connection with the provision of medical care and treatment to you that, for this purpose, also includes the identification and evaluation of alternative treatment options and health benefits available to you. For instance, WWA physicians and paramedical personnel involved in your care will use your PHI to plan a course of treatment for you that may include procedures, medications, tests, and *etc.* WWA may disclose your PHI to other health care providers who are also involved in your medical care and treatment.
3. **Coverage, Authorization and Payment.** WWA may disclose your PHI to health plans and/or other third party guarantors in connection with the following activities related to the provision of medical care and treatment to you: (a) confirming coverage, (b) securing required authorizations, and (c) billing and collecting payment. For instance, WWA may forward your PHI to your insurance company to arrange payment for medical services provided to you.
4. **Health Care Operations.** WWA may use and/or disclose your PHI in connection with our health care operations, including but not limited to the following activities: (a) appointment scheduling, (b) utilization review and management, (c) quality assessment and improvement, (d) peer review and corrective action, (d) clinical education and training, and (e) patient grievance and satisfaction. For example, WWA may use your PHI to remind you about appointments or to follow up on your visit. WWA may also use your PHI to evaluate the quality of care you receive from WWA physicians and paramedical personnel, or to review the performance of staff.

5. **Health Information Exchange (HIE)**. WWA may disclose your PHI to a local, regional and/or national *Health Information Exchange (HIE)*, but only for purposes related to treatment, payment, or health care operations, or as required by law. A HIE provides a mechanism for health care providers to share PHI electronically, with the goal of improving patient care while protecting the privacy and security of their PHI.
6. **Business Associates**. WWA may disclose your PHI to outside individuals or organizations, commonly referred to as “**business associates**,” who are not workforce members but who are engaged by WWA to furnish services in support of the operations of WWA, and who reasonably require access to your PHI in order to furnish such services. For example, WWA may disclose your PHI to a third party who is engaged by WWA to perform billing and collection services. In all cases, WWA requires business associates to agree in writing to safeguard the privacy and security of your PHI as required by applicable law.
7. **Research**. WWA may use and disclose your PHI for medical research, subject to your explicit authorization and/or oversight by an *Institutional Review Board (IRB)*, the committee which is responsible for approving the project and for protecting the privacy rights and safety of human subject research. For instance, the IRB may approve the use of your PHI with limited identifying information solely for the purpose of conducting outcomes research on the clinical efficacy of a particular procedure. The IRB will evaluate and implement confidentiality requirements to protect your PHI in all instances where you have not provided written authorization.
8. **Other Uses and Disclosures**. WWA may use or disclose your PHI without prior written consent or authorization from you in the following additional circumstances:
 - WWA may release your PHI for any purpose required by law
 - WWA may release your PHI for public health reasons, such as for required reporting of disease, injury, birth and death, and for required public health investigations
 - WWA may release your PHI to certain governmental agencies if WWA suspects child abuse or neglect, or if WWA believes you are a victim of abuse, neglect, or domestic violence
 - WWA may release your PHI to entities which are regulated by the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls
 - WWA may release your PHI to your employer if WWA provided medical care and treatment to you for purposes related to occupational health and safety, provided that in most cases you will receive written notice of disclosure to your employer
 - WWA may release your PHI if required by law to a government oversight agency conducting audits, investigations, inspections and health related oversight functions

- WWA may use or disclose your PHI in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public
- WWA may release your PHI if required to do so by a court or administrative order, subpoena or discovery request, provided that in most cases you will receive written of such release
- WWA may release your PHI to law enforcement officials in order to identify or locate suspects, fugitives, witnesses, or victims of crime, or for other allowable law enforcement purposes
- WWA may release your PHI to coroners, medical examiners, and/or funeral directors
- WWA may release your PHI, if necessary, to arrange an organ or tissue donation from you or a transplant for you
- WWA may release your PHI if you are a member of the military for activities set out by certain military command authorities as required by armed forces services
- WWA may also release your PHI, if necessary, for national security, intelligence, or protective services activities
- WWA may release your PHI if necessary for purposes related to your workers' compensation benefits

YOUR RIGHTS WITH RESPECT TO PHI

1. **Access to Your PHI.** Generally, you have the right to access, inspect, and/or receive paper and/or electronic copies of your PHI maintained by WWA. Requests for access must be in writing and be signed by you or your representative. WWA charges for copies of medical records in accordance with a schedule of fees established by state law. You can obtain an access request form from the WWA office.
2. **Amendments to Your PHI.** You have the right to request that your PHI maintained by WWA be amended or corrected. WWA is not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing and signed by you or your representative, and must state the reasons for the amendment/correction request. WWA may also ask its workforce and business associates if your amendment/correction request is necessary. In all events, WWA cannot delete any PHI already documented in your medical record even if WWA makes your requested amendment/correction. You can obtain an amendment/correction request form from the WWA office
3. **Accounting for Disclosures of Your PHI.** You have the right to receive an accounting of certain disclosures made by WWA of your PHI, other than disclosures made for purposes of treatment, payment, health care operations and certain other limited circumstances. The accounting would include only those disclosures made during the 6-year period prior to the date of the accounting request. Accounting

requests must be in writing and signed by you or your representative. WWA will not charge you for the first accounting request in any 12-month period; however, WWA will charge you a reasonable, cost-based fee for each subsequent request during the 12-month period. You can obtain an accounting request form from the WWA office.

4. **Restrictions on Use and Disclosure of Your PHI.** You have the right to request restrictions on certain uses and disclosures by WWA of your PHI for treatment, payment, and/or health care operations. WWA will attempt to accommodate reasonable requests. However, WWA is **not** required to agree to your restriction request. In addition, WWA retains the right to terminate any previously agreed-to restriction requests if necessary and appropriate, in which case WWA will notify you in writing. Without limiting the generality of the foregoing, if you request any restrictions on disclosures of your PHI to your health plan, then WWA cannot honor any such requests unless you or someone on your behalf, other than your health plan, pay for the health care item(s) or service(s) in full. WWA is not required to inform other providers of your request not to disclose your PHI, but WWA will attempt to do so where feasible. You can obtain a restriction request form from the WWA office.
5. **Confidential Communications.** You have the right to request communications regarding your PHI from WWA by alternative means or at alternative locations. WWA will endeavor to accommodate reasonable requests by you in that regard. Any requests for alternative communications of confidential information must be in writing and signed by you or your personal representative. You can obtain a confidential communication request form from the WWA office.
6. **Breach Notification.** WWA is required to notify you in writing of any breach of your unsecured PHI as soon as possible, but in no event later than sixty (60) days after WWA discovers the breach.
7. **Paper Copy of Notice.** You have the right to obtain a paper copy of this *Notice of Privacy Practices*, even if you requested a copy by e-mail or other electronic means.

ADDITIONAL INFORMATION

1. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint in writing with WWA or with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from WWA.
2. **Further information.** If you have questions or require further assistance regarding this *Notice of Privacy Practices*, then please contact WWA either by telephone at **310-657-3792** or in writing to **Ms. Kimberly Jaime, Compliance Officer, Wolfe, Wachtel & Artal, 8635 West Third Street, Suite 965, Los Angeles, CA 90048.**

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AGREEMENT TO FINANCIAL RESPONSIBILITY AND OFFICE POLICIES

Thank you for choosing **Wolfe, Wachtel and Artal (WWA)** as your health care provider. WWA is committed to providing quality medical care and looks forward to establishing a lasting professional relationship with you. As part of this relationship, WWA requests that you read and agree to comply with the financial responsibility and office policies set forth below.

FINANCIAL RESPONSIBILITY

Payment for services is considered part of your treatment. In general, WWA requires payment on the date that services are rendered. WWA accepts payment by cash, check, most major credit cards, and insurance for which WWA and/or your WWA physician is a contracted provider(s). WWA requires each patient to provide a photo ID. In addition, WWA requires each patient to present a current insurance card at each visit; *provided, however*, an insurance card does not confirm that coverage is effective and/or that coverage is available for medical services furnished or to be furnished by WWA. Subject to the foregoing provisions, WWA requires that you agree to and acknowledge the following:

- **Medicare Beneficiaries**
 - You authorize and direct that payments of benefits shall be made to WWA and/or your WWA providers in respect of medical services furnished to you
 - You authorize WWA to disclose your health information as and to the extent reasonably required to substantiate claims for payment in respect of medical services
 - You will be notified ahead of time if Medicare does not cover some or all of the medical services which your WWA provider recommends
 - You will be given an *Advance Beneficiary Notice (ABN)* to read carefully and then sign if you want to receive – and assume financial responsibility for – medical services which are not covered by Medicare

- **Commercial Insurance/Assignment of Benefits**
 - You are expected to understand your insurance coverage, including the scope of benefits, exclusions, referral and prior authorization requirements
 - WWA contracts with many insurance plans and, as a courtesy only, WWA will attempt to confirm the scope of your insurance coverage and benefits prior to treatment; *provided, however*, WWA is not responsible for inaccurate information provided by your insurance carrier; *provided, further*, you are and remain responsible for payment in respect of any medical services furnished by WWA
 - You authorize and direct WWA to disclose your health information as may be required to comply with certification, authorization and/or referral requirements

- You must provide WWA with current and accurate information regarding insurance, including prompt updates and/or changes to your insurance coverage
- WWA requires payments of deductibles and copayments at the time of service
- You authorize and direct that payment of benefits shall be made on your behalf to WWA in respect of medical services furnished to you by WWA providers
- You authorize WWA to disclose your health information as and to the extent reasonably required to substantiate claims for payment in respect of medical services
- If WWA and/or your WWA provider is/are a contracted provider(s), then WWA will submit a claim for reimbursement to the insurance carrier first and then bill you for the amount determined to be your financial responsibility
- If WWA and/or your WWA provider is/are not a contracted provider(s), then WWA will require full payment on the date of service and, upon receipt, provide you with a statement that you can submit to your insurance carrier for reimbursement; *provided, however*, WWA may, at its option and as a courtesy only, submit a claim for reimbursement on your behalf to the insurance carrier and then bill you for the amount determined to be your financial responsibility
- Whether or not WWA and/or your WWA provider is/are a contracted provider(s), WWA will require full payment at the time of service in respect of any and all medical services that are not covered by your insurance carrier; *provided, however*, WWA will inform you in advance that such services are not covered and the fees payable in respect of such services; *provided, further*, WWA will require your prior written consent to the assumption of financial responsibility for payment in respect of services that are not covered by your insurance carrier

OFFICE POLICIES

WWA desires to provide its patients with both high quality and cost effective medical services. In light of this goal, WWA requires that you agree to and acknowledge the following office policies:

- **Address Change**
 - WWA must have your correct address information on file
 - Please advise WWA promptly of any change(s) to your home/work address, telephone number(s) or other contact information
- **Timely Arrival and “No Shows”**
 - WWA reserves the right to reschedule any appointment for which you fail to arrive at least 15 minutes in advance of the scheduled time for the appointment
 - WWA reserves the right to assess a charge of \$75 if you miss an appointment and/or fail to cancel an appointment at least 24 hours in advance
- **Outstanding Balances and Returned Checks**
 - WWA reserves the right to reschedule an appointment for non-urgent medical services if you fail to pay an outstanding balance or co-payment or deductible
 - WWA will assess a charge of \$25 for any check returned for insufficient funds

• **Charges for Additional Services**

- WWA reserves the right to charge a fee to complete administrative forms (*e.g.*, DMV, physicals, FMLA, leave of absence, disability, and *etc.*)
- WWA reserves the right to charge the statutory fee for a copy of your medical record
- WWA reserves the right to charge a fee for a medication authorization
- WWA reserves the right to charge an annual fee for quarterly (or more frequent) preparation of prescriptions for controlled substances
- WWA reserves the right to charge a fee to measure FeNO (breath nitrogen oxide)
- WWA reserves the right to charge a fee for time expended by your WWA physician furnishing services on your behalf that are not covered by Medicare or commercial insurance, based on an hourly rate in 15 minute increments

WWA will inform you of the fee for the applicable service (or fee estimate in the case of the last category) and require your agreement to pay before WWA undertakes to perform

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The undersigned acknowledges having read and understood the financial responsibility and office policies set forth above. The undersigned further acknowledges that he/she is and remains responsible for payment in full in respect of all services furnished WWA to the patient identified below.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

By completing this form below, you acknowledge having received a copy of the *Notice of Privacy Practices* of **WOLFE, WACHTEL AND ARTAL** on the date and at the time specified below.

Please contact Ms. Kimberly Jaime, Compliance Officer, at 310-657-3792 if you have questions regarding the information contained in the *Notice of Privacy Practices*.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____ [a.m./p.m.]