The Village Sleep Lab & Breathing Center

Changing Lives. Overnight.

New Patient Forms Packet

Please print and fill out all the forms in this packet and bring them with you on your first visit.

Map/Directions to our location: 1400 US Hwy 441 N. Suite 942, The Villages, FL, 32159

NOTE: PLEASE DO NOT USE GPS!

From the south on Hwy 27/441:

1. North to traffic light at Morse Blvd (after passing St. Timothy's Catholic Church on your left).
2. Left on Morse Blvd.
3. Enter the rotary (traffic circle), then take the first exit (first right) onto El Camino Real.
4. Once on El Camino Real, go a very short distance (about 1/8 mile) and make the first right into Spanish Plaines Professional Park (a large directory sign marks the park's entrance).
5. Make an immediate right into the first parking area between the rows of buildings. The Sleep Lab is in the second building on your left. During the day, proceed to the first door, the Breathing Center. In the evening, proceed to the third door, The Village Sleep Lab, for the sleep study.

From the north on Hwy 27/441:

1. South to traffic light at Morse Blvd after passing the entrance to UF Health/The Villages Hospital.
2. Right on Morse Blvd.
3. See step 3 above.

From Morse Blvd (southwest):

1. Northeast on Morse Blvd to the rotary (traffic circle).
2. Enter the rotary and take the third exit (third right) onto El Camino Real.
3. See step 4 above.

From El Camino Real (northwest):

1. Southeast on El Camino Real. Just past UF Health/The Villages Hospital, turn left into the next entrance (at the large directory sign), before you get to the rotary.
2. See step 5 above.

Patient Information

Patient Name			Parents/Care of
Gender	Marital Status	Date of Birth / /	Patient's Social Security Number
Primary Doctor			Emergency Contact, Relationship, & Phone Number
Local Address (Street)_____ (City/St/Zip)_____			Other (seasonal) Address (Street)_____ (City/St/Zip)_____
Local Home Phone			Seasonal Home Phone
Local Work Phone			Seasonal Work Phone
Cell Phone			Email Address
Pharmacy (local retail)			Pharmacy (mail order)

Employer	Employee Type:	Student Type:
Employer Address (Street)_____ (City/St/Zip)_____	☐ Retired ☐ Employed Full Time ☐ Employed Part Time ☐ Not Employed	☐ Student Full Time ☐ Student Part Time ☐ Non Student

Insurance #1 (Primary)	
Insurer Address (Street)_____ (City/St/Zip)_____	Name of Insured_____ Gender_____ Marital Status_____ Relationship to Patient_____ Date of Birth_____/_____/_____ Policy Number_____ Group Number_____ Employer_____ Employer City/St/Zip_____

Insurance #2 (Secondary)	
Insurer Address (Street)_____ (City/St/Zip)_____	Name of Insured_____ Gender_____ Marital Status_____ Relationship to Patient_____ Date of Birth_____/_____/_____ Policy Number_____ Group Number_____ Employer_____ Employer City/St/Zip_____

Pediatric Services and Breathing Center
1400 N. US Highway 441, Suite 942, the Villages, FL 32159

Financial Agreement
Consent for Signature Use

Dr. Albino's Office Only Takes Original Medicare,and Most BlueCross/ Blue Shield Plans.

Our Office does not take any HMO'S or any MEDICARE ADVANTAGE PLANS.

I hereby authorize payment directly to Pediatric Services and Breathing Center of all Insurance benefits otherwise payable to me or my dependents for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I am also financially responsible to that my balance is paid on time.

I understand my responsibility of being thoroughly familiar with my insurance coverage for medical services rendered, including issues pertaining to co-payments, deductible, in-network and out-network coverage, referrals, approvals, authorizations necessary prior to obtaining any service.

In summary I am responsible for knowing what my insurance pays and does not pay and my responsibility given different circumstances.

I authorize Pediatric Services and Breathing Center, P.A. or the providers of supplier of Services in this office to release information required to secure the payment of benefits.

I understand that the physician's office will try to provide to vendors minimum necessary information under HIPPA regulations so that the vendors are able to justify to insurance providers any medical equipment or medications requested by the physicians.

However, often the physician's notes may refer to multiple medical problems and contain embedded medical information which cannot be removed practically and may not be directly pertinent to the equipment or medications that are being ordered to benefit the patient.

I authorize the use of this signature on all insurance submissions. By signing below I am also agreeing to follow the office policies and that I understand my financial obligations for all services rendered to me or my dependents by the practice.

_____ _____
Signature Date

_____ _____
Print Name Date

ACCREDITED
Facility Member™

JUAN A. ALBINO, M.D.
BOARD CERTIFIED IN SLEEP AND PULMONARY MEDICINE

THE VILLAGE SLEEP LAB & BREATHING CENTER

1400 U.S. Hwy. 441 N.
The Villages, FL 32159
Telephone: (352) 751-4955
Fax: (888) 716-2004
www.villagesleeplab.com

ACKNOWLEDGEMENT OF OFFICE POLICIES AND LIMITATIONS
THE VILLAGE SLEEP LAB AND BREATHING CENTER

1. Consultations Only Notice

I understand that I am seeing Dr. Albino (the Practice) in his capacity as a consulting, not primary or treating, physician. While Dr. Albino is Board Certified in Pulmonary, Critical Care, and Sleep medicine, I understand that he is not assuming care as a primary care physician (PCP). With this in mind, I understand that Dr. Albino's role in my medical care is in the diagnosis, short-term management, and stabilization of the single, specific condition for which he is being consulted. When these medical goals have been accomplished, my primary care physician will resume my main care with Dr. Albino as a consultant. In general, Dr. Albino will not care for simple respiratory infections, and I will seek care from my primary care physician for such conditions and other primary care needs. Patients are seen by appointment only, emergency health care is best given in an Emergency Room, and the provision of urgent care depends on the flexibility of a very busy appointment schedule. Dr. J. Albino consults and has privileges only at The Villages Regional Hospital.

2. Prescription Refill Notice and Record Request Notice

I am aware that the office policy is that all prescription refills require a 5-business day prior notice in order for the Practice to expeditiously and thoroughly handle such requests while allotting the proper resources to sudden urgent matters.

I am also aware that record requests may take 20 business days or so for the Practice to complete. Emergency record requests will be handled via a call from the requesting physician, and the Practice will supply the necessary information. Clearly, I need to plan ahead if records are necessary in order not to disrupt the work of the Practice.

3. Referral to Other Physicians or Testing Facilities Notice

I understand that Dr. Albino assumes no responsibility in arranging any appointments outside of the Practice. Dr. Albino's practice is in no way affiliated with the practice of any testing facilities to which I may have been referred, and we unfortunately have no control over their scheduling or provision of care. Dr. Albino is not responsible for follow-up unless and until he receives full feedback from the physician/facility, along with any laboratory, imaging or pathology results. It is not Dr. Albino's responsibility to guarantee obtaining these results. Consultations are usually secured by the primary care physicians.

4. Ordering of Tests Notice

I understand that if Dr. Albino orders a laboratory test, imaging study or any clinical test that is not being billed by the Practice, and it is rejected by my insurance company, then the Practice would be glad to help with the rejection as long as the following steps are taken:

A. The patient obtains from the billing department of the testing facility a copy of the billing claim (with diagnosis and procedural code) and a copy of the explanation of benefits indicating the denial and the reasons for the denial.
B. The billing supervisor of the testing facility calls our Office requesting assistance and indicating a willingness to cooperate with the Practice in the investigation and resolution of the issue.
C. I must ascertain from my insurance company the covered benefits pertinent to the testing procedures.
D. Above all, I understand that a claim rejection is a billing issue and not a clinical one and that I am ultimately responsible for the payment of such a bill.

5. Coordination of Care for patients with Lung Malignancies Notice

I understand that Dr. Albino does not coordinate the care of patients with lung malignancies since this has become a highly specialized field. Where feasible and indicated, Dr. Albino will gladly perform procedures such as Bronchoscopy, Thoracentesis, and/or consult with the hospital management at The Villages Regional Hospital, but will not assume the primary care of such patients.

6. Coordination of Care for patients with mainly Cardiac Disease Notice

When heart disease (e.g. heart failure) primarily causes shortness of breath, Dr. Albino is not responsible for the management and treatment since heart disease is not the expertise of the Practice; rather this is the purview of the primary care physician and cardiologist. Where feasible, Dr. Albino will assist in the management of shortness of breath due to primary lung disease, but with advanced heart disease, treatment for pulmonary disease is often not helpful in alleviating shortness of breath. The Practice also cannot handle other non-pulmonary causes of shortness of breath such an anemia, anxiety, or simply unexplained. If breathing problems are unexplained or not responsive to therapy, then I am encouraged to seek a second opinion.

7. Coordination of Care for patients with Chronic Sinusitis due to Allergies and/or Smoking Notice:

I understand that the treatment and follow up of chronic sinusitis is also beyond the scope of the Practice and is usually handled by allergists, ENT (Ear, Nose, and Throat surgeons), or some primary care providers.

8. Occupational Lung Disease Notice:

The Practice is not involved in lung diseases as they pertain to work situations or occupations. This field is usually handled by occupational health physicians or interested primary care providers, since much expertise is involved.

9. Clearance for Surgical Procedures Notice:

The primary care physician (PCP) is the first step in any surgical clearance and can usually clear the patient with minor pulmonary disease for surgery. The PCP or the surgeon may call on the Practice to clear a patient with severe primary lung disease or a patient with moderate primary lung disease, if it is appropriate, and an official request is made by the physician. The appropriate lead time must be given to set up the appointment as the Practice cannot set aside sick patients in order to cater to a surgical schedule. Emergency surgical clearance is handled in the hospital.

10. Appointments after Hospital Discharges Notice:

If Dr. Albino consults a patient in the hospital, he will then determine when the patient should follow up with the Practice. If Dr. Albino has not been consulted for a hospital patient, then the Practice needs to see the hospital records before assigning any follow up appointments. Presumably, if the patient had a serious pulmonary issue, then a pulmonologist should have been consulted in the hospital. Complications of surgical procedures or of interventional radiology that affect the lungs require an official consultation by the surgeon or PCP or radiologist and will be evaluated to see if they are within the scope of the Practice and the timelines of the appointment and follow up will be determined. Dr. Albino is not directly responsible for complications arising from procedures undertaken by other physicians that are not acknowledged by those physicians.

11. Referrals to Vendors Notice:

I understand that the Practice may write an order to a Vendor if I need oxygen, nebulizer treatments, or medical equipment. The Practice is not directly affiliated with any Vendor and has no control over their scheduling, or the quality of their products, or the follow up, or the provision of care, including that outside the Vendor's catchment area. The Practice may suggest a particular Vendor, but this does not imply an endorsement or recommendation of its products or services, but simply an expedient measure to assist the patient. I am free to accept, reject, or suggest any vendor.

12. Coordination of care for patients with Neuromuscular Disease Notice:

The care of patients with advanced neuromuscular disease and pulmonary insufficiency is best left to specialized medical centers that have the proper staff and equipment. The Practice cannot assume the care of these patients nor those who require tracheotomy care and/or ventilator support at home.

13. Availability Notice:

I understand that Dr. J. Albino may not be available at times to consult in my care and then my Primary Care Physician or another caring physician may have to call in another pulmonologist, or if I am in the emergency room or hospital, I may have to be transferred to another health care facility for appropriate pulmonary care.

I understand that the scope of the Practice and the patterns of care may change over time given the needs of the patients, concern for the appropriate regulations, and the resources available.

14. Annual Office Visit Notice:

I understand that Florida Law requires that I have a follow up, face to face, office visit with Dr. Albino at least *once a year* or Dr. Albino will not be able dispense any medications and/or medical equipment orders for me.

_____ _____

Patient signature Patient Name (please print)

_____

Date

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Operations

I, _____, understand that as part of my health care, Pediatric Services and Breathing Center, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as :

* A basis for planning my care and treatment
* A means of communication among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were actually provided
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health information for directory purposes
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Pediatric Services and Breathing Center, P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I futher understand that Pediatric Services and Breathing Center, P.A. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pediatric Services and Breathing Center, P.A. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by_____on_____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on_____.

The Village Sleep Lab & Breathing Center
Juan A. Albino, MD
1400 N US HWY 441, BLDG 940 The Villages, Fl. 32159

Addition to our Notice of Privacy Policies

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.

We are required by law to protect the privacy of your health information. We are also required to give you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.
The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our Privacy practices, we will provide to you a revised notice by direct mail or electronically as permitted by applicable law. In all cases, we will post the revised notice.

The Village Sleep Lab & Breathing Center collects written and electronic information to administer our business and to provide products, services and information of importance to our patients. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our patient's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

It is the legal duty of **The Village Sleep Lab & Breathing Center** to protect the individual's Health information and the HIPAA Privacy Rule gives individual a fundamental new right to be informed of the privacy practices of their health plans and most of their health care, as well as to be informed of their privacy rights with respect to their personal health information.

Protecting patient's privacy and securing their health information is a core requirement for the Medicare and Medicaid (E.H.R.) Electronic health record program. Our office is responsible for taking the steps needed to protect the confidentiality, integrity, and availability of health information and comply with HIPAA, Privacy and Security Rules, CMS Meaningful Use Requirements.

- **Your Health Information can be transmitted for and by electronic media, and maintained in electronic media format.**
- **For Treatment to all healthcare team members.**
- **For Health Care Operations, Insurance companies for payments.**
- **To provide you with information on your Preventive care/ Annual wellness benefits.**
- **Reminders, we may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders Preventive health indicators, either by phone or internet.**
- **For Public Health Activities** such as reporting or preventing disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency. **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Additional Restrictions of Use and Disclosure. Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including super-confidential information about you. "Super-confidential information" may include confidential information under Federal and Florida laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: Refer to Florida Law for additional information.

1. HIV/AIDS; 2. Mental health; 3. Genetic tests; 4. Alcohol and drug abuse; 5. Sexually transmitted diseases and reproductive health information; and 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

What Are Your Rights? You have the right to ask to restrict, the right to receive confidential communication, the right to see and obtain a copy, the right to ask to amend, and the right to a paper copy of this notice.
For more information concerning our Privacy Policies, please contact our HIPAA Officer, Cathy Sapp, at (352) 751-4955 Ext. 18.
You may also notify the Secretary of the U.S. Department of Health and Human services. We will not take any action against you for filing a complaint.

I have been given a copy of this updated Privacy Policy notice _____

Patient Signature Date

The Evaluation and Management of Symptoms In The Office That May Arise From The Lungs Or Sleep

Patient Name: _____ Date: _____

I understand that Dr. Albino is evaluating me for symptoms that may be related to the lungs or to sleep.

If he determines that such symptoms are not primarily due to lung, or sleep disease then he will not care for the presenting symptoms, in particular if I go to the hospital.

Evaluation of such symptoms will generally take 3 visits, and I may be discharged after the evaluation is completed, since Dr. Albino cannot care for diseases outside of his expertise or scope of practice.

_____ _____

(Print name) (Date)

_____

(Signature)

(For Office Use Only)

Explained the above to the patient
And noted patient's decision
Employee initials: _____

- ☐ Patient decided to not schedule an appointment with office, and will see another physician
- ☐ Patient needs more information
- ☐ Patient scheduled an appointment with our office: _____

10-2017

ACCREDITED
Facility Member™

JUAN A. ALBINO, M.D.
BOARD CERTIFIED IN SLEEP AND PULMONARY MEDICINE

THE VILLAGE SLEEP LAB & BREATHING CENTER

1400 U.S. Hwy. 441 N. Suite 942
The Villages, FL 32159
Telephone: (352) 751-4955
Fax: (888) 716-2004
www.VillageSleepLab.com

AGREEMENT TO CONSIDER A SLEEP STUDY

Patient Name: _____ Date: _____

Dr. Juan Albino has reviewed your referral and is happy to provide you with his professional, medical opinion regarding your sleep study conditions.

However, Dr. Albino can not order supplies without having a Diagnostic Sleep Study Report from your previous physician. It is the responsibility of the patient to contact the physician or facility to obtain your studies.
If you cannot obtain your studies you must agree that enough effort has been put into obtaining your prior studies.

If you are in agreement with these terms, please acknowledge your acceptance by signing below and we can proceed with scheduling an appointment.

_____ _____
(Print name) (Date)

_____
(Signature)

(For Office Use Only)

Explained the above to the patient
And noted patient's decision
Employee initials: _____

- ☐ Patient decided to not schedule an appointment with office, and will see another physician
- ☐ Patient needs more information
- ☐ Patient scheduled an appointment with our office: _____

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The Villages, FL 32159
Telephone: (352) 751-4955
Fax: (888) 716-2004
www.VillageSleepLab.com

Patient Name: _____ Date: _____

To all of our new patients, WELCOME! We would very much appreciate it if you would tell us how you heard about Dr. Albino. Please put a check in as many of the boxes that apply in the following list:

- ☐ Airheads Support Group
- ☐ Sleep Apnea Support Group
- ☐ Community Talk by Dr. Juan Albino
- ☐ Health Care Worker (nurse, therapist, etc.)
- ☐ Health Directory
- ☐ Hospital
- ☐ Newcomers Magazine

Phone Book:

- ☐ The Villages
- ☐ Century Link

- ☐ Physician Referral
- ☐ Radio Ad
- ☐ SearchtheVillages.com
- ☐ www.VillageSleepLab.com (website)
- ☐ The Villages Daily Sun Newspaper
- ☐ The Villages Magazine
- ☐ Word of Mouth (friends, neighbors)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At The Village Sleep Lab and Breathing Center we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 04/14/2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit The Village Sleep Lab and Breathing Center a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of The Village Sleep Lab and Breathing Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has
- already been taken.

Our Responsibilities

The Village Sleep Lab and Breathing Centeris required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will either provide you the revised Notice when you are in the office or mail or email you the revised Notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Heather S. Ellington, CMOM at (352) 751-4955.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members or your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in

your health record to assess the care and outcomes in your case and others like it. This information will then be used in effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, with our office by contacting you via telephone and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, you location and general condition.

Communication with your or you family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation: 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.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in food faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers of the public.

NOTICE OF PRIVACY POLICIES FOR THE VILLAGE SLEEP LAB & BREATHING CENTER

1400 US HWY 441 N.
Bldg 940
The Villages, FL. 32159

Phone: 352-751-4955
Fax: 888-716-2004