Counting Sheep

Sleep Disorder Solutions

Patient

Last: _____ First: _____ Middle: _____

Birthdate: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Emergency Contact/ Relation: _____ Mobile: _____ Email:_____

Who may we thank for referring you to our office? _____

Responsible Party for MINOR (if different than emergency contact):

Name: _____ Phone: _____ Email:_____

HIPAA Authorization/ Consent:

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: **www.hhs.gov**

I hereby authorize Counting Sheep

- ◯ To use and disclose my personal protected health information and any records necessary, according to HIPPA guidelines, in the normal course of treatment, referral, payment, insurance and healthcare operations.
- ◯ To use and disclose photos and/or videos of myself (or my child) taken by Counting Sheep for educational purposes and to measure progress.

I agree to allow the following person (‘s) access to information about my care and account.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Appointments/ Financials I hereby agree

- ◯ Counting Sheep may contact me via phone, email and text with reminders and confirmations.
- ◯ If applicable, it is permissible to text my child/teenager regarding their appointments.
- ◯ A parent /designated adult will be present for all appointments for children under age of 16
- ◯ To give a minimum of 48-hour notice to cancel or reschedule an appointment.
- ◯ I understand that any missed appointment will be considered a non-refundable visit.
- ◯ To pay prior to scheduling appointments

Patient/Parent/Guardian Signature: _____ **Date:** _____