PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

PATIENT NAME (**PLEASE PRINT**) DATE OF BIRTH

I understand that Salem Sleep Medicine, P.C. will use and disclose health information about me. I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health, history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that Salem Sleep Medicine may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care, including electronic communication via secure email (encrypted) and NextMD Patient Portal.

I also understand that I have the right to receive and review a written description of how Salem Sleep Medicine will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, physicians and other personnel of Salem Sleep Medicine, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of a summary of the most current version of Salem Sleep Medicine's Notice of Privacy Practices in effect will be posted in the reception area and available on the Website at salemsleepmedicine.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Salem Sleep Medicine is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By_____Date_____
(Signature of Patient or Legal Representative)

Acknowledgment 02/2020