



13000 Harbor Center Dr, #202, Woodbridge, VA, 22192
T 703-955-5355 F 703-955-5348

OPTIMAL SLEEP AND WEIGHT LOSS CLINIC POLICIES

This form contains information about our Policies and practices. Please read carefully in its entirety.

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.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 01, 2023, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations. The following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital



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stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.



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Patient Rights

Access: You have the right to look at or get copies of your protected health information, with limited exceptions. You must make a request in writing to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a letter to the address at the end of this notice. We can prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, or call (202) 619-0257 (or toll-free at (877) 696-6775), or go to the



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website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

Name of Contact Person:

Pascal Ngongmon. Tel: 703-955-5355. Address: 13000 Harbor Center Dr, #202, Woodbridge, VA, 22192

Notice of Nondiscrimination

Optimal Sleep and Weight Loss Clinic complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optimal Sleep and Weight Loss Clinic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you have any concerns or complaints, you can contact us at:

Mail: 13000 Harbor Center Dr. #202, Woodbridge, VA, 22192

Email: optimalsleepweightloss@gmail.com Tel: 703-955-5553 Fax: 703-955-5548

You can file a grievance in person or by telephone, mail, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov, or by mail or phone at:

U.S. Department of Health and Human Services, Office of Civil Rights

200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201
[1-800-368-1019](tel:1-800-368-1019), [1-800-537-7697](tel:1-800-537-7697) (TDD). Complaint forms are available at www.hhs.gov.

FINANCIAL POLICY

This form is to inform you of our billing practices and financial policy.

Insurance and Billing.

To verify if we accept your insurance, please contact our office. If we do not accept your insurance, we may be able to issue a letter of medical necessity for you to use to request for reimbursement from your insurance company. Payments you are responsible for are due prior to your visit/testing.

Payment Options.

Payment options accepted include cash and credit cards. Please ask our staff about all payment options.

Forms and Fees

There is a charge for all forms. Please allow up to 7 business days for completion of forms. All forms must be left at the front desk even if you bring them on the day of your appointment. Expedited processing of forms will be considered on a case-by-case basis and additional fees may apply. Payments must be made at the time forms are released. Please speak to our staff for details about forms and applicable fees. Letters: \$25 VA forms/letters: \$100



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Cancellation Policy:

If for any reason you must cancel or reschedule your appointment, you must give us 24 hours' notice to avoid a \$50 no-show or late cancelation fee. This fee is not billable to your insurance and is your responsibility. If you arrive more than 15 minutes late to your appointment, the appointment may be canceled or rescheduled. If you arrive late but less than 15 minutes late to your appointment, you may be asked to wait until the provider has an opening for you to be seen. For in-lab sleep study appointments, you must provide a minimum of 3 business days cancellation notice to avoid a \$150 no-show or late cancelation fee. This fee is not billable to your insurance and is your responsibility.

If you have any questions regarding these policies, please speak to our staff and we would be happy to assist you.

I hereby authorize my insurance benefits to be paid directly to the physician and/or physician group for which I am financially responsible for all charges. I also consent to the release and re-disclosure of my medical record to enable or facilitate the payment, collection, verification, or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan.

Our office will obtain a general breakdown of your insurance benefits from your insurance carrier. This information can be provided to you upon request. This information is not a guarantee of benefits; we highly recommend that you contact your insurance carrier to get more specific approval for all services.

If at any point you change insurance, or your insurance policy terminates or cancels coverage, you will be fully responsible for all charges that are not subject to being refiled with any new insurance provided. Most insurance(s) have timely filing requirements and if they are not met, we are not able to rebill those services. It is imperative that you notify our office immediately of any changes to your policy. If we are unable to refile your claims, you will be fully responsible for all charges. This includes any SECONDARY insurance related information as well.

REFERRAL POLICY

I understand that if my insurance carrier requires a written "Insurance Referral" from my Primary Care Physician, I am responsible for obtaining the insurance referral prior to being seen in our office and prior to testing. We recommend that all patients call and confirm this directly with your health insurance or check with your PCP office ahead of time. If an "insurance referral" has not been obtained before my appointment, I will be asked to sign a "Waiver Form" acknowledging that if the referral is not able to be obtained timely, I will be financially responsible for the charges incurred.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees, and court costs. I have read and I understand all of the above and have agreed to these statements.

Signature of patient or authorized representative : _____

Print name of Patient or authorized representative: _____

If authorized representative, please state relationship to patient: _____

Date: _____