Sleep Wellness Clinics of America, PLLC
Bijoy E. John, M.D., FCCP
580 Franklin Road, Suite 200
Franklin, TN 37069
TEL (615) 685-4670 FAX (833) 563 -1716
www.sleepwellnessinfo.com

AUTHORIZATION TO RELEASE BILLING INFORMATION:

Patient's name:_____D.O.B:_____

I hereby authorize the treating provider to release any information required in the course of my examination or treatment to my insurance company, providers, individuals and entities authorized by me or their contracted entities. [If the patient is a minor, the parent or legal guardian must sign].
Please note that the use of all daily authorized and released records are not under Sleep Wellness Clinics control.

• AUTHORIZATION FOR PATIENT PICTURE: I hereby authorize Sleep Wellness Clinics to take a picture for my electronic medical records if I do not produce a current Photo ID.

_____

Signature of Patient/Patient's Representative (above) Date:

ASSIGNMENT OF BENEFITS TO SLEEP WELNESS CLINCS:

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by **Sleep Wellness Clinics** and the medical professionals caring for me during my treatment in this office to be paid directly to **Sleep Wellness Clinics**, or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance. This assignment will remain in effect until revoked in writing by me.

_____

Signature of Patient/Patient's Representative Date :

Printed Patient Name :_____

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Patient name : **D.O B**

ACKNOWLEDGMENT OF RECEIPT OF Health Insurance Portability and Accountability Act of 1996 (HIPAA) PRIVACY PRACTICES AND CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.
By signing this form, I hereby acknowledge that I have had the opportunity to read the Notice of Privacy Practices of **Sleep Wellness Clinics** and understand that in compliance with that notice, **Sleep Wellness Clinics i**s allowed to use or disclose my individually identifiable health information for purposes of treatment, payment, and health care operations. I further understand that the Notice of Privacy Practices provides a more complete explanation of the use or disclosure of my individually identifiable health information.
I have read a copy of the **Sleep Wellness clinics of America's** HIPAA Notice of Privacy Practices and understand the information it contains.

_____
Signature of Patient/Patient's Representative (above) Date:

TELEMEDICINE PROGRAM /TELEMEDICINE PATIENT CONSENT FORM I, (name of patient or parent guardian)_____agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or video conference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].
I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.
I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.
I understand that some or all of my medical information may be used for teaching or educational purposes.

Signature of patient (or parent/guardian): _____

Please print the above name: _____ Date:_____