Name: _____ Date: _____

Review of Systems

Do you CURRENTLY have any of the following?
Boxes left blank indicate "no".

General
[ ] Marked weight change
[ ] Night sweats
[ ] Tire easily

Eyes
[ ] Change in vision, double vision

Head
[ ] Headaches, dizziness, trauma

Neck
[ ] Swelling
[ ] Thyroid, goiter

Ears
[ ] Change in hearing
[ ] Ringing in ears

Nose
[ ] Bleeding
[ ] Obstruction
[ ] Sinus infection
[ ] Snoring

Urologic
[ ] Blood in urine
[ ] Increased frequency of urination
[ ] Kidney infection
[ ] Kidney stones

Heart and Lungs
[ ] Chest pain/tightness
[ ] Difficulty breathing lying down
[ ] High blood pressure
[ ] Palpitations
[ ] Shortness of breath
[ ] Swelling of ankles
[ ] Wheezing

Digestive
[ ] Abdominal pain
[ ] Bloody stool
[ ] Constipation
[ ] Diarrhea
[ ] Heart burn
[ ] Vomiting

Hematologic
[ ] Anemia
[ ] Bleeding disorder

Reproductive
[ ] Impotence
[ ] Lack of sex drive

Nervous System
[ ] Depression, mental illness
[ ] Dizziness
[ ] Fainting
[ ] Memory loss
[ ] Seizures

Musculoskeletal
[ ] Pain in joints

Throat
[ ] Hoarseness
[ ] Soreness

Mouth
[ ] Lumps or ulcers
[ ] Sore gums or tongue

Breasts
[ ] Masses

Other: _____

_____

_____

_____

Allergies: _____

_____

_____

_____

Name: _____ Date: _____

Past Medical History

Have you ever had any of the following?
Boxes left blank indicate "no".

[ ] Asthma/emphysema
[ ] Bleeding tendency
[ ] Cancer
[ ] COPD
[ ] Diabetes
[ ] Heart disease/heart attack
[ ] Hepatitis/liver disease
[ ] High blood pressure
[ ] HIV/AIDS
[ ] Kidney disease
[ ] Tuberculosis
[ ] Chronic fatigue
[ ] Fibromyalgia
[ ] Sleep apnea

Other: _____

_____

_____

Have any blood relatives had any of the following?

[ ] Chronic lung disease
[ ] Diabetes
[ ] Heart disease
[ ] High blood pressure
[ ] Obesity
[ ] Sleep apnea

Personal Habits

[ ] Alcohol: drinks per week: _____
[ ] Non-prescribed drugs
[ ] Caffeine: cups per day: _____
[ ] Regular exercise
[ ] Tobacco use: packs per day: _____

Current and past Occupations

_____

_____

_____

Operations

[ ] Tonsillectomy
[ ] Nasal
[ ] Heart
[ ] Thyroid

Other operations

_____

_____

Medications

Name	Reason for Taking Medication
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____
(for Medical History and Review of Systems)

Please list you doctors including addresses and phone numbers. It is very important that we as able to communicate with them.

Primary Care Physician: _____ Phone: _____

Address: _____

_____

_____

Sleep Physician: _____ Phone: _____

Address: _____

_____

_____

Dentist: _____ Phone: _____

Address: _____

_____

_____

Other: _____ Phone: _____

Address: _____

_____

_____

Patient Name _____ Date _____

Epworth Sleepiness Scale (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing
It is important that you circle a number (0 to 3) on each of the questions.

Situation	**Chance of Dozing (0 to 3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place - for example, a theater or meeting	0 1 2 3
A passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

Total Score:

Fatigue Severity Scale (FSS)

This scale reflects the fatigue you felt in the past week and how it impacts you.
The lower numbers indicate less fatigue while the higher numbers indicate more fatigue.
It is important that you circle a number (1 to 7) for every question.

During the past week:	**No** **Yes**
I felt fatigued and had less motivation	1 2 3 4 5 6 7
I felt fatigued and did not desire to exercise	1 2 3 4 5 6 7
I felt fatigued often	1 2 3 4 5 6 7
I felt fatigue that interfered with my physical functioning	1 2 3 4 5 6 7
I felt fatigued which caused me frequent problems	1 2 3 4 5 6 7
I felt fatigued which prevented sustained physical functioning	1 2 3 4 5 6 7
I felt fatigued and couldn't carry out certain duties and responsibilities	1 2 3 4 5 6 7
Fatigue was among my three most disabling symptoms	1 2 3 4 5 6 7
Fatigue interfered with my work, family or social life	1 2 3 4 5 6 7

Total Score:

Rawa Dental Sleep Medicine
Documentation of Intolerance to CPAP/BiPAP
(Continuous Positive Air Pressure)

I have attempted to use nasal CPAP/BiPAP to manage my sleep disordered breathing (obstructive sleep apnea) and find it intolerable to use on a regular basis due to the following reason(s):

[ ] CPAP is not effective in controlling my symptoms

[ ] I was unable to complete my sleep study using CPAP

[ ] I was unable to sleep with CPAP equipment in place

[ ] The noise from the device disturbs my sleep or my bed partner's sleep

[ ] I cannot find a comfortable mask

[ ] The mask leaks

[ ] I develop sinus / throat / ear / lung infections

[ ] I am allergic to materials in the mask and head straps

[ ] Claustrophobia

[ ] I unconsciously remove the CPAP apparatus at night

[ ] The pressure of the mask and straps cause tissue breakdown

[ ] My job and/or lifestyle prevent this form of therapy (e.g., Business Travel / Active Army / National Guard duty)

[ ] Prior throat surgery made CPAP intolerable or I have discontinued using CPAP

[ ] Other

[ ] I have refused to have a sleep study trial using CPAP because:

_____

Because of my inability to tolerate CPAP and my need to control my PSA and reduce comorbidities, I wish to use an alternative method of treatment. This form of therapy is oral appliance therapy (OAT).

Signed: _____

Print Name: _____ Date: _____

Rawa Dental Sleep Medicine

Assignment of Benefits / Medical Information Release

Patient Name: _____ Date of Birth: _____

Mailing Address: _____

Address City State Zip

Home Phone: _____ Cell Phone: _____

Marital Status: S M D W Other _____ Occupation: _____

Patient Employer: _____ Work Phone: _____

Employer Address: _____

Address City State Zip

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

Insurance Information – Please Provide Your Insurance Card / Driver's License

Primary Insurance: _____ Subscriber: _____ DOB _____

Secondary Insurance: _____ Subscriber: _____ DOB _____

List person you want us to share your health information with:

Name: _____ Phone: _____

Mailing Address: _____

Emergency Contact: _____ **Relationship to patient**: _____

Home Phone: _____ **Work Phone**: _____

Assignment of Benefits / Medical Release

The above information is true to the best of my knowledge. I authorize any holder of Medical Information about me to release to Rawa Dental Sleep Medicine, my physician(s), caregiver, CMS or its agents. I hereby authorize Rawa Dental Sleep Medicine to submit claims to my insurance company for my treatment and release any medical or other information necessary to process my claim. I authorize my insurance benefits to be paid directly to Rawa Dental Sleep Medicine for services rendered and understand that I am financially responsible for any charges not covered by my insurance.

Signed: _____ Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO RAWA DENTAL SLEEP MEDICINE

Patient: _____

DOB: _____

Address: _____

SSN: _____

I hereby authorize _____ [health care provider] to release information from the record of the above-named patient to Rawa Dental Sleep Medicine.

The records are for the purpose of treatment of sleep-disordered breathing / obstructive sleep apnea. Release any information related to diagnosis, treatment and history of sleep disorders and sleep-disordered breathing. Records to be released include: Medical History, Exam, Office Visit Notes, and Diagnostic/Therapeutic Sleep Studies.

HIV information contained in the parts of the record(s) indicated above will be released through this authorization.

I understand the following:

- That my health record(s) will not be released unless permission if provided for herein as evidence by the signature on the Authorization for Release of Protected Health Information (Authorization).
- That the release of my health record(s) will be for the purpose stated on this form, and only those items indicated will be released.
- That the health record(s) released by the facility/person authorized above may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- That this Authorization is in effect for a period of one year from the date of signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That I have right to revoke this Authorization form at any time by sending a written request to the entity where the authorization was provided.
- That my decision to revoke the Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the Authorization.
- That I am entitled to a copy of this completed Authorization form.

I understand that this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on the consent has already been taken) by written, dated and signed communications to the provider. This consent will expire in one year from date signed, unless otherwise stated as follows: _____.

A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I understand that recipients may re-disclose information which I have authorized them to receive.

_____ _____

Signature of Patient Date

Rawa Dental Sleep Medicine

INFORMED CONSENT FOR THE TREATMENT OF SNORING AND/OR OBSTRUCTIVE SLEEP APNEA WITH AN ORAL APPLIANCE

Snoring and Obstructive Sleep Apnea are both breathing disorders that occur during sleep due to the narrowing or total closure of the airway. Snoring is a noise created by the partial closure of the airway and may occasionally be no more problematic than the noise itself. However, consistent loud, heavy snoring has been linked to medical disorders such as, high blood pressure and daytime sleepiness. Obstructive sleep apnea is a serious condition where the airway totally collapses many times during the night and can significantly reduce oxygen levels in the body and disrupt sleep. In varying degrees, this can result in excessive daytime sleepiness, irregular heartbeat, increased risk of high blood pressure and occasionally heart attack and stroke. It may also increase the risk of diabetes and depression.

Because any sleep-disordered breathing may potentially represent a health risk, all individuals are advised to consult with their physician or sleep specialist for accurate diagnosis of the condition before treatment can be started.

Oral appliances may be helpful in the treatment of snoring and sleep apnea. Those diagnosed with mild or moderate sleep apnea are better candidates for improvement with this therapy than those severely affected. Oral appliances are designed to assist breathing by opening the airway space in the throat during sleep. While documented evidence exists that oral appliances have substantially reduced snoring and sleep apnea for many people, there are no guarantees this therapy will be successful for every individual. Several factors contribute to the snoring/apnea condition including nasal obstruction, narrow airway space in the throat and excessive weight. Since each person is different and presents with unique circumstances, oral appliances will not reduce snoring and/or sleep apnea for everyone. Furthermore, some people may not be able to tolerate the appliance in their mouth. Other treatment options include weight loss, positional therapy, continuous positive airway pressure (CPAP) and surgery. Polysomnography (sleep test) and other objective tests following treatment will be necessary to document effectiveness of the appliance therapy.

It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time, you may still experience symptoms related to your sleep-related breathing disorder. Additionally, durable medical equipment such as your oral appliance require specific home care, maintenance and periodic replacement.

Side Effects

Most individuals will notice temporary side effects such as excessive salivation, sore jaw joints and muscles, dry mouth, sore teeth and a slight change in "bite". However, these are generally minor and usually diminish within an hour after appliance removal each morning.

Complications

Many times, a permanent bite change will occur due to the permanent movement of teeth or from permanent jaw joint repositioning due to the forces of the appliance each night. A permanent bite change of this nature can have damaging long-term effects on the teeth, musculature and jaw joint and should be managed by an experienced dentist. If this should occur, options include discontinuing use of the appliance, bite adjustment (slight reshaping of certain teeth), restoration with crowns, orthodontic intervention (braces) and occasionally consultation with a temporomandibular joint specialist with the costs being borne by you. Bite exercise and the use of a morning bite splint each day will minimize the possibility of permanent bite changes occurring.

Occasionally, people are unable to tolerate the appliance in their mouths and may need to discontinue use of the appliance. Over time, the components of the appliance may become worn out or broken. If pieces separate from the appliance, there is a chance they may be swallowed or aspirated into the lungs. Broken or loosened teeth, dislodged dental restorations, mouth sores and inflamed gums may occur. On occasion, food may become impacted between

teeth during chewing. It is very important that you contact your PDSM office if the appliance becomes loose or ill fitting. A proper fit is crucial for safety and good results.

Periodic Examinations

It is advised that the oral appliance be checked at least twice a year for the first year to ensure proper fit and that your mouth be examined at that time to ensure a healthy condition. If any unusual symptoms occur, it is recommended that the appliance not be used until an office visit is scheduled to evaluate the situation. After the first year of treatment, annual examinations are required.

If periodic exam appointments are not attended as prescribed, potential complications are more likely to become detrimental. It is your responsibility to comply with the regular examinations to review the harmony of your bite and to ensure your future dental health. Dr. Rawa must provide these examinations unless you relocate from the Pittsburgh area.

The oral appliance is strictly a mechanical device to maintain an open airway during sleep. It does not cure your snoring or sleep apnea. Therefore, the device must be used nightly for a lifetime to be effective. Untreated sleep apnea can result in an increased risk of heart attack, stroke, high blood pressure and accidents. Please see Dr. Rawa prior to discontinuing use and for treatment options.

Follow-Up Sleep Test

Individuals who have been diagnosed as having sleep apnea may notice that after sleeping with an oral appliance, they feel more refreshed and alert during the day. This is only subjective evidence of improvement and may be misleading. The only way to accurately measure whether the appliance is keeping the oxygen levels sufficient and breathing normal is to have a follow-up sleep test while utilizing the appliance. This is a must for apnea patients.

I understand my responsibilities to be:

1. To submit to regular, periodic evaluations as determined by Dr. Rawa for the length of treatment. (Every six months for the first year and annually thereafter).
2. To notify Dr. Rawa of any discomfort or change in my bite, mouth, jaw joint or teeth (other than the minor changes described above).
3. To notify Dr. Rawa of any damage to the appliance or ill fit.
4. To comply with daily jaw joint exercises and use the morning bite splint as instructed.
5. To submit to a follow-up sleep test utilizing the oral appliance when requested to do so.

I consent to the taking of photographs and x-rays before, during and after treatment and their use in scientific papers and presentations. I certify that I have had the opportunity to read and have had explained to me the content of this form and that my questions have been answered and I have been shown a demonstration appliance. I realize and accept any risks and limitations involved and do consent to treatment. I hereby give consent to Dr. Rawa's clinical team to consult with my healthcare providers regarding this disorder and to exchange medical records to assist in the management of my disorder. My signature below indicates I have read and understand this information concerning oral appliances for the treatment of snoring and/or sleep apnea, and that I am willing to accept any and all risks known and unknown involved. I understand I will receive a copy of this disclaimer if I request one.

Patient signature: _____ Date: _____

Witness: _____

Rawa Dental Sleep Medicine, 10A Liberty Lane, Latrobe PA 15650
724-539-7781

Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC

Medicare DMEPOS Supplier Standards (30) Statement: The products and/or services provided to you by your supplier are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g.., honoring warranties, hours of operations). The full test of these standards can be obtained from the following website:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DMEPOSSupplierStandards.pdf

Patient Rights & Responsibilities

Patient Rights:

1. The patient has the right to considerate and respectful service.
2. The patient has the right to obtain service without regards to race, color, nation origin, sex, age, disability, diagnosis or religious affiliation.
3. Subject to applicable law, the patient has the right to confidentiality of all information pertaining to his/her medical equipment service. Individuals or organizations not involved in the patients care, may not have access to the information without the patient's written consent.
4. The patient has the right to make informed decisions about his/her care.
5. The patient has the right to reasonable continuity of care and service.
6. The patient has the right to voice grievances without fear of termination of service or other reprisal in the service process.

Patient Responsibilities:

1. The patient should promptly notify Rawa Dental Sleep Medicine of any equipment failure or damage.
2. The patient is responsible for any equipment that is lost or stolen while in their possession and should promptly notify Rawa Dental Sleep Medicine in such instances.
3. The patient should promptly notify Rawa Dental Sleep Medicine of any changes to their address or telephone.
4. The patient should promptly notify Rawa Dental Sleep Medicine of any changes concerning their physician.
5. The patient should promptly notify Rawa Dental Sleep Medicine of discontinuance of use.
6. Except where contrary to federal or state law, the patient is responsible for any equipment rental and sale charges which the patient's insurance company/companies does not pay.

Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC
Notification of Information Practices

The purpose of the consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of the provider or organization.

Your consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and 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 my diagnosis/es and other health information to my bill(s).
- A source of information for applying my diagnosis/es and other health information to my bill(s).
- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care and competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC.
- I have the right to review the Notice of Information Practices prior to signing this consent.
- Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, can change its Notice of Information Practices but notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided.
- I have 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 and that Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, is not required to agree to those restrictions.
- Any restrictions to which Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction.

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices and Patient Rights & Responsibilities.

_____ _____

(Signature of Patient) (Date)

We are required by law to make the following information available to you. You do not need to print it. You can save it in a file or delete it.

We have paper copies in the office if you need another copy.

Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC

Notice of Privacy Practices

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

A. ***Our Commitment to your privacy:***

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

*How we may use and disclose your identifiable health information

*Your privacy rights in your identifiable health information

*Our obligations concerning the use and disclosure of your identifiable health information

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit.

B. ***If you have any questions about this notice, please contact***: Compliance officer, Rawa Dental Sleep Medicine and Dentistry with a Touch of Art, LLC, 724-539-7781.

C. ***We may use and disclose your health information in the following ways:*** The following categories describe the different ways in which we may use and disclose your identifiable health information:

1. **Treatment**. Our organization may use your identifiable health information to treat you. For example, we may perform a follow-up interview and we may use the results to help us modify your treatment plan. Many of the people who work for our organization may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, therapists, spouse, children or parents.
2. **Payment**. Our organization may use and disclose your identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties who may be responsible for such costs, such as family members. Also, we may use your identifiable health information to bill you directly for services and items.
3. **Health Care Operations**. Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities of our practice.
4. **Appointment Reminders**. Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.
5. **Health-Related Benefits and Services**. Our organization may use and disclose your identifiable health information to inform you of health-related benefits or services that may be of interest to you.
6. **Release of Information to Family/Friends**. Our organization may release your identifiable health information to a friend or family member who is helping you pay for your health care of who assists in taking care of you.
7. **Disclosure Required By Law**. Our organization will use and disclose your identifiable health information when we are required to do so by federal, state or local law.

D. ***Use and disclosure of your identifiable health in certain special circumstances.*** The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our organization may disclose your identifiable health information to public health authorities who are authorized by law to collect information for the purpose of:

a. Maintaining vital records, such as births and deaths
b. Reporting child abuse or neglect
c. Preventing or controlling disease, injury or disability
d. Notifying a person regarding potential exposure to a communicable disease
e. Notifying a person regarding a potential risk for spreading or contracting a disease or condition
f. Reporting reactions to drugs or problems with products or devices
g. Notifying individuals if a product or device they may be using has been recalled
h. Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
i. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our organization may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedure or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws, and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our organization may use and disclose your identifiable health information in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release identifiable health information if asked to do so by a law enforcement official:
    a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    b. Concerning a death we believe might have resulted from criminal conduct
    c. Regarding criminal conduct at our offices
    d. In response to a warrant, summons, court order, subpoena, or similar legal process
    e. To identify/locate a suspect, material witness, fugitive or missing person
    f. In an emergency, to report a crime (including the location or victim (s) of the crime, or the description, identity or location of the perpetrator)
5. **Serious Threats to Health or Safety.** Our organization may use and disclose your identifiable health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
6. **Military.** Our organization may disclose your identifiable health information if you are a member of US or foreign military forces (including veterans) and if required by the appropriate military command authorities.
7. **National Security.** Our organization may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Workers' Compensation.** Our organization may release our identifiable health information for workers' compensation and similar programs.

E. ***Your rights regarding your identifiable heath information.*** You have the following rights regarding the identifiable health information that we maintain about you.

1. **Confidential Communication.** You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, 10A Liberty Lane, Latrobe PA 15650, specifying the requested method of contact or the location where you wish to be contacted. Our organization will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your identifiable health information for the treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of disclosure of your identifiable health information, you must make your request in writing to Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 10 A Liberty Lane, Latrobe PA 15650. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 10 A Liberty Lane, Latrobe PA 15650, in order to inspect and/or obtain a copy of your identifiable health information. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 10 A Liberty Lane, Latrobe PA 15650. You must provide us with a reason that supports your request for the amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 10 A Liberty Lane, Latrobe PA 15650. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before October 1, 2006.
6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 724-539-7781.
7. **Right to file a complaint.** If you believe your privacy rights have bene violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint with our organization, Compliance Officer, Rawa Dental Sleep Medicine/Dentistry with a Touch of Art, LLC, 10 A Liberty Lane, Latrobe PA 15650. All complaints must be in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an authorization for other uses and disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will not longer use or disclose your identifiable health information for the reasons described in the authorization. Please note that we are required to retain records of your care.