

Dentistry with a Touch of Art, LLC

10A Liberty Lane

Latrobe PA 15650

724-539-7781

Designation of an Authorized Representative

An Authorized Representative is a person you authorize to act on your behalf, in pursuing a claim or an appeal of a denied claim. This authorization may be (1) granted for a particular event or date of service, after which time the authorization approval is revoked or (2) granted for any present or future claim for health care benefits you may have. Designations of Authorized Representative status granted for a particular event or date of service are most appropriated when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of Authorized Representative status for any present or future claim for health care benefits are more appropriately made to family members or other trusted persons who you may wish to authorize to assist you in the future with health care claim matters.

I, _____, hereby appoint Dr. John Rawa as an authorized Representative to act on my behalf in the filing or pursuance of claims and pursuance of appeals in connection with any following health care claims (either present or future) dealing with the delivery of my oral sleep appliance.

I understand that as a result of this authorization, my insurance carrier may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the individual named above.

This designation is subject to revocation at any time by the designator except to the extent that the patient's insurance company may have taken action in reliance on this designation before they knew of the revocation. If not previously revoked, this designation will terminate four years from date of signature.

(print name of patient)

(signature of patient)

(date)

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. PLEASE REVIEW CAREFULLY.

This Notice is effective February 16, 2026 and replaces all earlier versions.

- I. Our organization is committed to protecting health information about you. We create a record of the health care and service you receive at **Dentistry with a Touch of Art, LLC** for use in your care and treatment. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all the records of your care relating to services provided in the hospitals, outpatient and ambulatory care centers and other facilities that comprise the **Dentistry with a Touch of Art, LLC**, as well as the physicians and other health care professionals who provide services within those entities. If your personal health care provider is not an employee of **Dentistry with a Touch of Art, LLC**, then your provider may have different policies or Notices regarding how information maintained by the provider's office or clinic is used or disclosed about you.

We are required by law to:

- **Make sure that your health information is protected;**
- **Give you this Notice describing our legal duties to protect your privacy;**
- **Follow the terms of the Notice that is currently in effect; and**
- **Notify you in the event of a breach of your unsecured protected health information (PHI) as required by law.**

You have a right to receive a copy of and discuss this Notice with our Privacy Office at the number or address listed at the end of this Notice.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:

The following sections describe ways that an entity may use and disclose your protected health information. For each category of uses or disclosures, we will describe them and give some examples. Some information, such as genetic information, certain drug and alcohol information, HIV information and mental health information may be entitled to special restrictions by state and federal laws. We abide by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed; however, all the ways we are permitted to use and disclose information will fall within one of the following categories.

A. For Treatment - We may use protected health information about you to provide you with treatment or services. We may disclose your health information with other professionals involved in your care, agencies, or facilities not affiliated with **Dentistry with a Touch of Art, LLC**, provide or coordinate the different things you need, such as prescriptions, lab work, and X-rays. We may disclose this information with people who are involved in taking care of you. We may contact you to provide appointment reminders, obtain patient registration information, information about treatment alternatives or other health-related benefits and services that may be of interest to you or to follow up on your care.

B. For Payment - We may use and disclose your protected health information for billing and payment activities of **Dentistry with a Touch of Art, LLC**, and others involved in your care, such as an ambulance company. For example, we may use and disclose information so that **Dentistry with a Touch of Art, LLC**, or others involved in your care can obtain payment from you, an insurance company or another third party. We may also tell your health insurance company about a treatment you need to obtain for prior approval or check if your insurance will pay for the treatment.

C. For Healthcare Operations - We may use and disclose your health information for our health care operations, which are various activities necessary to run our business, provide quality health care services and contact you when necessary. We may disclose your protected health information to medical or nursing students and other trainees for review and learning purposes

D. Health Information Exchange (HIE) We may participate in an electronic Health Information Exchange ("HIE") to facilitate the sharing of your protected health information for treatment purposes. An HIE is a network in which providers participate in exchanging patient information in order to facilitate health care.

E. Business Associates and Service Providers: We may disclose your protected health information with third parties referred to as "Business Associates". Business Associates provide various services to or for **Dentistry with a Touch of Art, LLC**. Examples include billing services, transcription services and legal services. We ensure that all Business Associates and service providers, regardless of their location, are obligated to protect your PHI in accordance with U.S. and international laws, including the Health Insurance Portability and Accountability Act (HIPAA). These measures include implementing appropriate safeguards to protect the privacy and security of your information.

F. Required by Law – We will disclose protected health information about you when required to do so by federal, state, and/or local law. This includes, however, is not limited to, disclosures to mandated patient registries, including reporting adverse events with medical devices, food, or prescriptions drugs to the Food and Drug Administration. We may also disclose protected health information to health oversight agencies for activities authorized by law. This includes but is not limited to the U.S. Department of Health and Human Services, accrediting agencies, auditors, and public health activities when preventing disease, helping with product recalls and reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence. We may also disclose health information for law enforcement purposes as required by law or in response to a valid subpoena, summons, court order or similar purpose.

G. Research: We may use and disclose your protected health information for certain research purposes in compliance with the requirements of applicable federal and state laws. All research projects, however, are subject to a special approval process, which establishes protocols to ensure that your protected health information will continue to be protected, when required, we will obtain a written authorization from you prior to using or disclosing your protected health information for research.

H. Substance Use Disorder (SUD) Treatment Information: If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general written consent you provide to the Part 2 Program to use and disclose the SUD record for purposes of treatment, payment or health care operations, we may use and disclose your SUD records for treatment, payment or health care operations as described in this Notice. If we receive or maintain your SUD record through specific consent you provide us or another third party, we will use and disclose your SUD record only as expressly permitted by you in your written consent as provided to us.

In no event will we use or disclose your SUD record, or testimony that describes the information contained in your SUD record, in any civil, criminal, administrative or legislative proceedings by any Federal, State or local authority against you, unless authorized by your consent or court order (after you are notified of the court order).

I. Facility Directories (Hospital Inpatients only) - Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care (for example: room number or emergency room) and your general condition. The directory information may be released to people who ask for your name so your family, friends and clergy may visit you in the hospital and generally know how you are doing.

J. Individuals Involved in Your Care or Payment for your care: Unless you tell us not to, we will disclose your health information with anyone involved in your health care, such as a friend, family member or any individual you identify. If you are unable to agree or object, for example, if you are not present or are unconscious, we may disclose protected health information as necessary if we determine that it is in your best interest based on our professional judgment. Additionally, we may disclose information about you to your legal representative.

K. Legal Proceedings, Lawsuits and Other Legal Actions: We may disclose protected health information about you to courts, attorneys, court employees and others when we receive a court order, subpoena, discovery request, warrant, summons or other lawful instructions. We may also disclose information about you to *Dentistry with a Touch of Art, LLC*, attorneys and/or attorneys working on *Dentistry with a Touch of Art, LLC*, behalf to defend ourselves against a lawsuit or action brought against us. We may disclose your protected health information to the police or other law enforcement officials to report or prevent a crime as otherwise required or permitted by law.

L. Fundraising Activities – We may contact you to raise funds and provide information about *Dentistry with a Touch of Art, LLC*, activities, including fundraising programs and events. You may request to “opt-out” of fundraising communications if you do not wish to be contacted. Please email your request to deanna@rawadental.com or call 724-539-7781 to leave a message identifying yourself and stating that you wish to opt out.

M. We may use and disclose your protected health information in the following special situations:

- **Disaster Relief** - We may use or disclose your health information with an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose health information about you with organ procurement organizations. We may also disclose health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers’ Compensation and Other Government requests:** We may use or disclose health information about you for workers’ compensation claims
- **National Security and Intelligence Activities**
- **Military:** If you are a member of the armed forces, domestic (United States) or foreign; we may disclose protected health information about you to the military authorities as authorized or required by law.
- **Protective Services for the President of the United State and Others:** We may disclose protected health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

N. Artificial Intelligence or AI: We may utilize AI technology to support operational decisions and recommendations about your treatment or care, including but not limited to documenting care, supporting clinical assessments, treatment recommendations, creating a care plan, and billing. AI technology may use your information to train and improve AI technology’s functionality. AI technology partners (Business Associates) are required to keep your information confidential.

O. (If Applicable) Sharing Information within an OHCA: We maintain our Designated Record Set through the use of an electronic health record (“EHR”). Through this EHR, your medical information is combined with that of other health care providers or “Covered Entities” that participate in the EHR (each, a “Participating Covered Entity” and collectively, the “Participating Covered Entities”), such that each of our patients, including you, have a single, longitudinal health record with respect to all services provided by the Participating Covered Entities. Through the EHR, the Participating Covered Entities have formed one or more organized systems of health care in which the Participating Covered Entities participate in joint utilization review and/or quality assurance activities, and as such qualify to participate in Organized Health Care Arrangement(s) (“OHCA(s)"). As OHCA participants, all Participating Covered Entities, including us, may use and disclose the protected health information contained within the EHR for the Treatment, Payment and Health Care Operations purposes of each of the OHCA participants.

III. YOU HAVE THE RIGHT TO ACCESS YOUR PROTECTED HEALTH INFORMATION BY CONTACTING THE LOCATION WHERE YOU RECEIVED YOUR CARE OR BY CALLING THIS NUMBER AT THE END OF THIS NOTICE.

In addition to your rights as a patient, we also ask that you respect the rights of other patients by not discussing any information you may see or hear while receiving services in our facilities.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information we maintain about you:

- A. Right to Inspect and obtain an Electronic or Paper Copy of your Protected health Information** – With certain exceptions, you have the right to inspect and/or receive an electronic or paper copy of your protected health and billing records and other health information used by us to make decisions about your care. You may request that we send a copy of your protected health information to a third party. To inspect and/or receive a copy of your protected health records we request you submit a request in writing to your *Dentistry with a Touch of Art, LLC* provider or the appropriate health information department. If you request a copy of your protected health records, we may charge you a reasonable cost-based fee for the cost of providing you with the copies. Under certain circumstances, we may deny your request to inspect or copy your records. If we deny your request, we will explain the reasons to you and in most cases, you may have the denial reviewed.
- B. Right to Request an Amendment** - You may request that we amend health information about you that you think is incorrect or incomplete. You may ask us to correct the information if the information is kept by or for *Dentistry with a Touch of Art, LLC*, in your protected health and billing records. To request an amendment, your request must be submitted in writing to the *Dentistry with a Touch of Art, LLC*, Privacy Office and

provide the reasons for the request. If we agree to your request, we will amend your record(s) and notify you of such. In certain circumstances, we cannot remove what was in the record(s), however we may add supplemental information to clarify. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

- C. **Right to an Accounting of Disclosures** – You have a right to receive a list of certain disclosures we have made of your protected health information in the six (6) years prior to the date of your request. To request an accounting of disclosures, you must submit your request in writing to the **Dentistry with a Touch of Art, LLC**, Privacy Office. You must state the time period for which you want to receive the accounting, which may not date back more than six years from the date of your request. The first accounting you receive in a 12-month period will be free. We may charge you for responding to additional requests in that same time period.
- D. **Right to Request Restriction** – You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You alone have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. If we agree to your request, we will comply with your request unless the information is needed to provide you with emergency treatment, or we are required by law to disclose it. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations of the health plan, and the information pertains solely to a protected health item or service for which you have paid out-of-pocket in full. To request a restriction, you must make your request to the **Dentistry with a Touch of Art, LLC**, Privacy Office and tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both and (3) to whom you want the limits to apply, i.e. disclosures to your spouse. We are allowed to end the restriction if we tell you. If we end the restriction, it will only affect the protected health information that was created or received after we notify you.
- E. **Right to a Paper Copy of This Notice** – You have the right to have a paper copy of this notice at any time, even if you have previously agreed to receive a copy of this Notice electronically. Copies of this Notice are available **Dentistry with a Touch of Art, LLC**, facilities, on our website, www.rawadental.com or by contacting the **Dentistry with a Touch of Art, LLC**, Privacy Office as shown below.
- F. **Right to Choose Someone to Act for You** – If you have given someone healthcare power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information. We will verify that the person has this authority and can act for you before we take action or disclose information.

IV. Uses of Medical Information Requiring Authorization

- A. **Psychotherapy Notes** - We must obtain your written permission to disclose psychotherapy notes except in certain circumstances. For example, written permission is not required for use of those notes by the author of the notes with respect to your treatment or use or disclosure by us for training of mental health practitioners, or to defend **Dentistry with a Touch of Art, LLC**, in a legal action brought by you.
- B. **Marketing** - We must obtain your written permission to use or disclose your medical information for marketing purposes except in certain circumstances. For example, written permission is not required for face-to-face encounters involving marketing, or where we are providing a gift of nominal value (example: a coffee mug), or a communication about our own services or products (example: we may send you a postcard announcing the arrival of a new surgeon or x-ray machine).
- C. **Sale of Medical Information** - We must obtain your written permission to disclose your medical information in exchange for remuneration.
- D. **Other Uses and Disclosures** - Other uses and disclosures of your medical information not covered by the categories included in this Notice or applicable laws, rules or regulations will be made only with your written permission or authorization. If you provide us with such written permission, you may revoke it at any time. We are not able to take back any uses or disclosures that we already made with your authorization. We are required to retain your medical information regarding the care and treatment that we provide to you.

V. CHANGES TO THIS NOTICE - We reserve the right to change this Notice and **Dentistry with a Touch of Art, LLC** privacy practices. We reserve the right to make the revised or changed Notice effective for protected health information we already have about you as well as any information we receive in the future. The new notice will be available upon request and on our web site. This Notice will specify the effective date of this Notice.

VI. QUESTIONS/COMPLAINTS - If you believe your privacy rights have been violated, you may file a complaint with **Dentistry with a Touch of Art, LLC** or with **Dentistry with a Touch of Art, LLC** Privacy Officer. You will not be retaliated against for filing a complaint.

Privacy Officer
Dentistry with a Touch of Art, LLC
724-539-7781
info@rawadental.com
10A Liberty Lane, Latrobe PA 15650

Or with the Secretary of the Department of Health and Human Services:

U.S. Dept. of Health and Human Services
Office for Civil Rights
2000 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775

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 text 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)

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 our 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 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: _____

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:

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

- headache, 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 _____

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

Medications

Name

Reason for Taking Medication

Personal Habits

- alcohol: drinks per week: _____
- non-prescribed drugs
- caffeine: cups per day: _____
- regular exercise
- tobacco: packs per day: _____

Current and Past Occupations

Operations

- tonsillectomy
- nasal
- heart
- thyroid

Other operations

Signature _____ Date _____

(for Medical History and Review of Systems)

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

Primary Care Physician: _____ Phone: _____

Address: _____

Sleep Physician: _____ Phone: _____

Address: _____

Dentist: _____ Phone: _____

Address: _____

Other: _____ Phone: _____

Address: _____

**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 is provided for herein as evidenced 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 the 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