PAYMENT POLICY

Patient Responsibility:
You are responsible for all charges resulting from treatment provided by Southern Pulmonary and Sleep, LLC. We bill most insurance carriers; however, primary responsibility for the account is yours. Your co-payment is always due at the time of service. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

Insurance Billings:
It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.

I hereby certify that I (or my dependent) have the insurance coverage that I (or my dependent) presented and assign all benefits directly to Southern Pulmonary and Sleep, LLC, if any, otherwise payable to the services rendered.

Check Returned:
It is our office policy to charge a $25.00 fee for checks that are returned.

Authorization to Release Information:
In obtaining payment for services, I authorize my healthcare provider, Southern Pulmonary and Sleep, LLC./Mark Knower, MD to release all information necessary from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies or their representatives and my employer or union if they are involved in processing the claim. I authorize the use of this signature for all insurance submissions.

If I have been referred by, or am being referred to, another healthcare provider, I authorize Southern Pulmonary and Sleep, LLC to release my medical information to this provider for continuing care.

I also assign Southern Pulmonary and Sleep, LLC all payments to which I am entitled for medical expenses related to the services reported herewith.

HIPPA:
I acknowledge that I have received a copy of the Southern Pulmonary and Sleep, LLC’s Notice of Privacy Practices.

Consent:
I hereby authorize Southern Pulmonary and Sleep, LLC’s physician and staff to administer or perform medical treatment including procedures or services as they may deem necessary or reasonable including pulmonary function test, laboratory services, radiology studies and diagnostic procedures.

I OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Patient Name (Please Print)  Patient’s Signature  Date

If Patient is under 18 years of age or is Otherwise Unable to Sign, Complete the Following:
Patient is _______ year(s) of age or is unable to sign because: ________________________________

Signature  Relationship to Patient  Date
CANCELLATION AND NO SHOW POLICY

EFFECTIVE JANUARY 1, 2017

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide at least 24 hours’ notice. This will enable us to accommodate another patient who is waiting for an appointment.

Patients who do not show up for a scheduled appointment, and who have not contacted our office at least 24 hours before the appointment will be considered a NO SHOW.

- Appointments which are not cancelled within 24 hours will be charged a $25.00 fee.
- This fee is charged to the patient, not the insurance company, and is due at the time of the patient’s next office visit.
- Patients who No-Show three (3) or more times may be dismissed from the practice, thus they will be denied future appointments.

We do realize circumstances can change at the last minute. If you were unable to make a scheduled appointment due to extenuating circumstances, please contact our Medical Assistant at (985) 273-3035 X203, who may be able to waive the No Show fee.

_________________________________________ Date of Birth ________________
Patient Name (Please Print)

_________________________________________ Date ________________
Signature of Patient or Patient Representative

101 Judge Tanner Blvd. · Suite 506 · Covington, LA 70433 · (985) 273-3035 Office · (985) 273-3036 Fax
ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION AUTHORIZATION

1. I certify that I (or my dependent) have the insurance coverage that I presented and assign all benefits directly to Southern Pulmonary and Sleep, LLC, if any, otherwise payable to the services rendered.

2. I understand that I am financially responsible for all charges whether or not paid for by my insurance company.

3. I hereby authorize the doctor(s) to release all information necessary to secure the payment of benefits. I authorize the use of the signature for all insurance submissions.

4. I acknowledge that I have received a copy of Southern Pulmonary and Sleep, LLC’s Notice of Privacy Practices.

5. I hereby authorize Mark Knower, MD and Southern Pulmonary and Sleep, LLC’s staff, to administer or perform medical treatment including procedures or services as they may deem necessary or reasonable including pulmonary function test, laboratory services, radiology studies and diagnostic procedures.

Signature ___________________________ Date ___________________________

Printed Name ___________________________ Description of relationship if not patient
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _________________________ (print name) hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Southern Pulmonary and Sleep, L.L.C.

________________________  __________________________
Signature                        Date

________________________
Printed Name

If not signed by the patient, please indicate relationship:

__ Parent or guardian of minor patient;
__ Power of Attorney, Tutrix, Curator or Designated Personal Representative

________________________
Name of Patient

__ Acknowledgment refused:

Efforts to obtain:

________________________
________________________
Reason for refusal:

________________________
DESIGNATION OF PERSONAL REPRESENTATIVE

You have a right as required by the Health Insurance Portability and Accountability Act of 1996 to nominate one or more persons to act on your behalf with respect to the protection of your health information. By signing the authorization you are informing us of your designation of the named person as your Personal Representative. This designation may be revoked at any time by signing and dating the revocation of your copy of the form and returning it to this office.

I, __________________________ hereby designate __________________________, to act as my Personal Representative with respect to decisions involving the use and/or disclosure of my health information.

Last Four (4) Digits of Representative’s SS No: __________________________
Representative’s Date of Birth: __________________________
Representative’s Driver’s License No. or Other Picture ID No.: __________________________

It is my understanding that this person is to be afforded all of the privileges that would be afforded to me with respect to my health information unless specifically restricted below:

Restrictions: __________________________

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to SOUTHERN PULMONARY AND SLEEP, L.L.C., 101 Judge Tanner Blvd., Suite 506, Covington, Louisiana 70433. I further understand that such revocation does not apply to the extent that persons who have been authorized by my Personal Representative to use or disclose my health information have already acted in reliance on said designation.

_________________________________________  __________________________
Signature                                      Date

_________________________________________  __________________________
Last four (4) digits of SS#                      Date of Birth

REVOCATION

I hereby revoke this designation of a personal representative.

_________________________________________  __________________________
Signature                                      Date
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification
Printed Name: ___________________________ Date of Birth: ___________________________
Address: _________________________________________________________________________
________________________________________________________________________________
Social Security #: ___________________________ Telephone No.: ___________________________

Authority to Release Protected Health Information

I hereby authorize ___________________________ (Patient's Name) to release information identified in
this authorization from the medical records of ___________________________. Fax to (985) 273-3036.

Information to be Released - Covering the Periods of Health Care From (date) ____________ to ____________

☐ Complete Medical Record

☐ Partial Medical Record specifically to include:

☐ History and Physical Exam ☐ X-ray Reports ☐ Itemized Bill
☐ Laboratory Test Results ☐ X-ray Films/Images ☐ Other (specify)
☐ Photographs & Videotapes ☐ Discharge Summary
☐ Diagnosis & Treatment Codes ☐ Progress Notes
☐ Consultation Reports ☐ Complete Billing Record

Purpose of the Requested Disclosure of Protected Health Information - I am authorizing the release of my Protected Health
Information for the following purposes (e.g. a purpose may be "at the request of the individual"): At patient's request.

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release - I understand if my medical or billing
record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C
testing, and/or other sensitive information, I agree to its release. Check One: Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency
Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release. Check One: Yes No

Expiration Date - Unless revoked, this authorization will expire on the following date, or after the following time period or event: 10
years.

Right to Revoke Authorization - Except to the extent that action has already been taken in reliance on this authorization, this
authorization may be revoked at any time by submitting a written notice.

Re-disclosure - I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may
no longer be protected by the Health Insurance Portability and Accountability Act of 1996.

Signature of Patient or Personal Representative Who May Request Disclosure - I understand that I do not have to sign this
authorization, and my treatment or payment for services will not be denied if I do not sign this form. However, if health care services
are being provided to me for the purpose of providing information to a third-party, I understand that services may be denied if I do not
authorize the release of information related to such health care services to the third-party. I can inspect or copy the protected health
information to be used or disclosed. I hereby release and discharge Southern Pulmonary and Sleep, LLC, its employees, agents and
owners of any liability and the undersigned will hold them harmless for complying with this authorization.

Signature: ___________________________ Date: ___________________________

Description of Relationship if not patient: ____________________________
### PATIENT REGISTRATION FORM

**Patient Information (Please Print)**

Name: ____________________________ Sex: M F

Address: ____________________________________________________________

City: __________________ State: ___________ Zip Code: ___________

**Mailing Address (if different from above)**

Address: ____________________________________________________________

City: __________________ State: ___________ Zip Code: ___________

Telephone: (Home) __________________________ Telephone: (Other) ______________

Email: ___________________________________________________________

Social Security Number: __________________________ D.O.B.: ______________

In Case of Emergency Notify: _______________________________________

@ Telephone: __________________________

Primary Care Physician (PCP): _______________________________________

@ Telephone: __________________________

City: __________________ State: ___________ Zip Code: ___________

Signature: ______________________________________________________
Notice of Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices is adopted to ensure that SOUTHERN PULMONARY AND SLEEP, L.L.C / MARK T. KNOWER, M.D. (the Clinic), fully complies with all federal and state privacy protection laws and regulations, in particular, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protection of patient privacy is of utmost importance to the Clinic. The Clinic is required by law to maintain the privacy of protected health information and to provide its patients with a copy of its Notice of Privacy Practices outlining its legal duties and privacy practices with respect to protected health information. Violations of any of these provisions will result in disciplinary action which may include termination of employment and possible referral for criminal prosecution.

This Notice of Privacy Practices shall become effective as of April 8, 2014, and shall remain in effect until it is either amended or cancelled.

You have a right to receive a paper copy of this Notice of Privacy Practices. If you have any questions or comments concerning this notice, you should contact the Chief Privacy Officer, SOUTHERN PULMONARY AND SLEEP, L.L.C / MARK T. KNOWER, M.D. , 101 Judge Tanner Blvd., Suite 506, Covington, Louisiana 70433, Telephone No.985-273-3035, Facsimile No. 985-273-3036.

DEFINITIONS

For the purposes of this notice, the following defined terms shall have the following definitions.

a. “HHS” shall mean the United States Department of Health and Human Services.

b. “Health Information”, “Protected Health Information” or “PHI”, shall mean certain Individually Identifiable Health Information, as defined in 45 C.F.R. § 164.501 of the Privacy Standards.

I. Information Collected

In the ordinary course of business the Clinic may receive personal information such as:

• Patient’s name, address, and telephone number;
• Information relating to treatment, diagnosis or other medical information concerning a patient;
• Patient’s insurance information and coverage.

In addition, other information will be gathered about a patient and we will create a record of the care and/or services provided to the patient by the Clinic. Some of the information also may be provided to us by other individuals or organizations that are part of the patient’s “circle of care”- such as a patient’s referring physician, other doctors, health plan, family members, hospitals or other health care providers.

Revised 4/8/2014
II. How the Clinic May Use or Disclose a Patient’s PHI

The Clinic collects PHI from the patient and stores it in an account file. This is the patient’s medical record. The medical record is the property of the Clinic, but the information in the medical record belongs to the patient. The Clinic protects the privacy of the patient’s PHI. It is the policy of the Clinic that all PHI may not be used or disclosed unless it meets one of the following conditions:

1. The use or disclosure is for treatment, payment or healthcare operations.
   
a. Treatment. The Clinic collects information from the patient regarding the patient’s past medical history, present medical problems and/or complaints, as well as any diagnosis and or medical treatment at the Clinic. This information may be transmitted to various departments within our organization, the patient’s referring physician and other entities associated or involved in the patient’s treatment. This information may also be disclosed to the patient’s physicians in association with the patient’s treatment including, but not limited to, any physical therapy or home health entities.

   b. Payment. The Clinic will collect billing information from the patient such as the patient’s present address, social security number, date of birth, health insurance carrier, policy number and any other related billing information. The Clinic may disclose to the patient’s health insurance provider, Medicare, Medicaid or other payor of healthcare claims the minimum amount necessary of the patient’s PHI in order to process the patient’s health insurance claim.

   c. Regular Healthcare Operations. The Clinic may disclose the patient’s healthcare information to physicians, medical assistants, nurses, nurse practitioners, physician assistants, radiology personnel, MRI technologists, billing clerks, administrative staff and other employees involved in the patient’s healthcare treatment.

2. The patient, who is the subject of the information, through a written authorization has authorized the use or disclosure of the information. This authorization may be revoked by the patient providing the Clinic with a written revocation of said authorization. Without the patient’s authorization, the Clinic may not disclose the patient’s psychotherapy notes. The Clinic may also not use or disclose the patient’s PHI for the Clinic’s own marketing and may not sell the patient’s PHI.

3. The patient, who is the subject of the information, does not object to the disclosure of their PHI to persons involved in the health care of the individual or for facility directory purposes.

   a. Notification and communication with family. We may disclose the patient’s PHI to notify or assist in notifying a family member, the patient’s personal representative or another person responsible for the patient’s care about the patient’s location, their general condition, or in the event of the patient’s death. If the patient is able and available to agree or object, we will give the patient the opportunity to object prior to making this notification. If the patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient’s family and others.

4. Voice Mail Message. It is the policy of the Clinic that a voice mail or answering machine message may be left at a patient’s home or other number the patient provides to the Clinic regarding appointments, billing or payment issues, or other PHI, related to treatment, payment or healthcare operations.

5. As Required by Law. It is the policy of the Clinic that we may use and disclose a patient’s PHI as required by law.

Revised 4/8/2014
a. Public health. As required by law, we may disclose a patient’s PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

b. Health oversight activities. We may disclose a patient’s PHI to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

c. Judicial and administrative proceedings. We may disclose a patient’s PHI in the course of any administrative or judicial proceeding.

d. Law enforcement. We may disclose a patient’s PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and/or for other law enforcement purposes.

e. Decedent information. We may disclose a patient’s PHI to coroners, medical examiners and funeral directors.

f. Organ donation. We may disclose a patient’s PHI to organizations involved in procuring, banking or transplanting organs and tissues.

g. Research. We may disclose a patient’s PHI to researchers conducting research that has been approved by an Institutional Review Board or the Clinic’s Board of Directors.

h. Public safety. We may disclose a patient’s PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

i. Specialized government functions. We may disclose a patient’s PHI for military, national security and prisoner purposes.

j. Worker’s compensation. We may disclose a patient’s PHI as necessary to comply with worker’s compensation laws.

k. Marketing. We may contact a patient to provide appointment reminders or to give the patient information about other treatments or health-related benefits and services that may be of interest to the patient.

l. Fundraising. We may use certain information (name, address, telephone number or email information, age, date of birth, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money for the Clinic and you will have the right to opt out of receiving such communications with each solicitation. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services at the Clinic.

m. Change of Ownership. In the event that the Clinic is sold or merges with another organization, the patient’s PHI will become the property of the new owner.
III. Other Policies, Uses and Disclosures

1. **Notice of Privacy Practices.** It is the policy of the Clinic that privacy practices must be published and that all uses and disclosures of PHI are done in accordance with the Clinic's privacy policy. The Clinic is required by law to abide by the terms of its Notice of Privacy Practices.

2. **Deceased Individuals.** It is the policy of the Clinic that privacy protections extend to information concerning deceased individuals.

3. **Restriction Requests.** It is the policy of the Clinic that serious consideration must be given to all requests for restrictions on uses and disclosures of PHI as published in this privacy policy. The patient has the right to request restrictions on certain uses and disclosures of their PHI. The patient may do so by completing the Clinic's form entitled "Restrictions". The Clinic is not required to agree to the restriction that the patient requests. If a particular restriction is agreed to, the Clinic is bound by that restriction. If a patient pays for a specific health product or service out of pocket, the patient has the right to request that the Clinic not disclose their information to their insurer. Such a request can also be made in writing by completing the Clinic's form entitled "Restriction-Self Pay" and checking the particular box indicating that the service or product was paid for by the patient. If such a request is made, the Clinic must agree with the patient's request.

4. **Minimum Necessary Disclosure.** It is the policy of the Clinic that it shall make reasonable efforts to limit the disclosure to the minimum amount of information needed to accomplish the purpose of the disclosure. It is also the policy of the Clinic that all requests for PHI must be limited to the minimum amount of information needed to accomplish the purpose of the request.

5. **Access to Information.** It is the policy of the Clinic that the patient has the right to inspect and copy their PHI. It is the Clinic's policy that access to PHI must be granted to a patient when such access is requested. Such request shall be submitted in writing by completing the Clinic's request form entitled "Request for Inspection and/or Copy of Protected Health Information". Costs associated with the copying of any PHI shall be in accordance with applicable state and federal law.

6. **Designation of Personal Representative.** It is the policy of the Clinic that access to PHI must be granted to a patient's designated personal representative as specified by the patient when such access is requested and authorized by the patient. This designation of a personal representative must be made in writing by completing the Clinic's form entitled "Designation of Personal Representative".

7. **Confidential Communications Channels.** It is the policy of the Clinic that the patient has the right to receive their PHI through a reasonable alternative means or at an alternative location. Confidential communication channels can be used within the reasonable capability of the Clinic, (i.e., do not call me at work, call me at home) as requested by the patient. Such request shall be made in writing by completing the Clinic's form entitled "Confidential Channel Communication Request".

8. **Amendment of Incomplete or Incorrect Protected Health Information.** It is the policy of the Clinic that a patient has a right to request that the Clinic amend their PHI that is incorrect or incomplete. The Clinic is not required to change a patient's PHI and will provide the patient with information about the Clinic's denial and how the patient can disagree with the denial. A request to amend a patient's PHI shall be made in writing by completing the Clinic's form entitled "Request for Amendment of Health Information".

9. **Accounting of Disclosures.** It is the policy of the Clinic that an accounting of disclosures of PHI made by the Clinic is given to the patient whenever such an accounting is requested in writing. The patient has a right to receive an accounting of disclosures of their PHI made by the Clinic. Such written request for an accounting shall be made by completing the Clinic's form entitled "Request for Accounting of Disclosures".

Revised 4/8/2014
10. **Breach Notification.** It is the policy of the Clinic as required by law to maintain the privacy of a patient’s PHI and to provide the patient with a copy of our legal duties and privacy practices relating to their PHI. If there is a breach (an inappropriate use or disclosure of the patient’s PHI that the law requires to be reported) the Clinic must notify the patient of said breach.

11. **Underwriting and Genetic Information.** The Clinic is prohibited from using or disclosing a patient’s PHI that is genetic information (information about genetic tests or genetic illnesses of the patient or their family members) for the purposes of eligibility, continued eligibility, enrollment, determination of benefits, computing premium or contribution amounts, pre-existing condition exclusion or other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

12. **Complaints.** It is the policy of the Clinic that all complaints by employees, patients, providers or other entities relating to PHI be investigated and resolved in a timely fashion. Complaints about this Notice of Privacy Practices or how the Clinic handles a patient’s PHI should be directed to:

   Southern Pulmonary and Sleep, L.L.C.
   Attn: Privacy Officer
   101 Judge Tanner Drive #506
   Covington, Louisiana 70433

   If a patient is not satisfied with the manner in which this office handles a complaint, the patient may submit a formal complaint to:

   Department of Health and Human Services
   Office of Civil Rights
   Hubert H. Humphrey Bldg.
   200 Independence Avenue, S.W.
   Room 509F HHH Building
   Washington, DC 20201

13. **Prohibited Activities.** It is the policy of the Clinic that no employee may engage in any intimidating or retaliatory acts or actions against any person who files a complaint or otherwise exercises their rights under HIPAA regulations. It is also the policy of the Clinic that no disclosure of PHI will be withheld as a condition for payment for services from the patient or from an entity.

14. **Responsibility.** It is the policy of the Clinic that the responsibility for designing and implementing procedures related to this policy lies with the Chief Privacy Officer.

15. **Mitigation.** It is the policy of the Clinic that the effects of any unauthorized use or disclosure of PHI be mitigated (to decrease the damage caused by the action) to the extent possible.

16. **Business Associates.** It is the policy of the Clinic that Business Associates must be contractually bound to protect a patient’s PHI to the same degree as set forth in this policy.

17. **Preemption of State Law.** It is the policy of the Clinic that the federal privacy regulations are the minimum standard to be used regarding the privacy of a patient’s PHI. If the laws of the State of Louisiana are more stringent in certain areas, the state laws in these areas shall prevail. In all other areas, the federal privacy regulations shall prevail.

Revised 4/8/2014
18. **Cooperation with Privacy Oversight Authorities.** It is the policy of the Clinic that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of PHI within this organization. It is also the policy of the Clinic that all personnel cooperate fully with all privacy compliance review and investigations.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact the Chief Privacy Officer of the Clinic.

IV. **Changes to this Notice of Privacy Practices**

The Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future and will provide a copy of such amendment to the patient upon request or upon the patient's next visit. Until such amendment is made, the Clinic is required by law to comply with this notice.