



Hello,

I would like to be the first to welcome you to Somnique Health. It is my pleasure to introduce you to our team. My name is Vivek Dogra, MD. I am the Medical Director here at our facility. I will see you in consultation and follow-up and also interpret your sleep study. I will spend time with you to discuss any issues you are having with your sleep and we will come up with a long term, positive resolution for you.

I would also like to tell you about our Clinical Manager, Joedi Robinson. She is completely devoted to helping each and every client, so please feel free to call her as she is always available to answer any clinical questions you may have. I am here to assist you with any questions or concerns you may have during your time with us as well.

You have probably scheduled your appointment with one of our medical receptionists, Keiry or Giselle. They are also available to answer any questions you may have. They are dedicated to making sure each client is greeted with a warm welcome, and that all of your needs are met.

At Somnique Health we pride ourselves on doing our absolute best to make sure each and every client has a pleasant experience. Your well-being is our #1 priority and that is echoed every step of the way. If you feel as though you have not received superior care from the beginning of your experience with Somnique Health, please do not hesitate to contact either Joedi or I. It is very important to all of us that you are taken care of. Again, thank you so much for choosing to work with us.

Please call us with any questions.

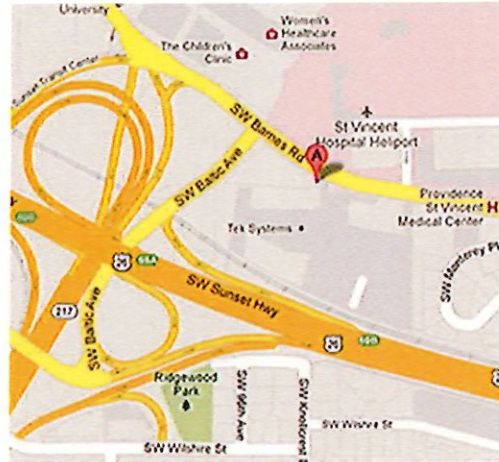
Sincerely,

Vivek Dogra, M.D.  
Medical Director  
Somnique Health  
(503)688-5536

# Somnique Health

9450 SW Barnes Road Suite 140 Portland, OR 97225

Phone: 503-688-5536



## Directions

### **From I-5 North**

1. Merge onto I-5 South
2. Take exit 302B for Interstate 405/US 30W. Continue to follow I-405 South.
3. Take exit 1D to merge onto US-26 W toward Beaverton
4. Take exit 69B toward Park Way / Barnes Road
5. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
6. Turn right onto SW Barnes Road
7. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **From I-5 South**

1. Merge onto I-5 North
2. Take Exit 292A to merge onto OR-217 N toward Tigard/ Sunset Hwy/ Oregon Coast
3. Take the Barnes Road exit
4. Keep right at the fork, follow signs for Barnes Road E and merge onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **From Highway 26 East**

1. Merge onto US-26 W
2. Take exit 69B toward Park Way / Barnes Road
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **From Highway 26 West**

1. Merge onto US-26 E
2. Take exit 69B toward Park Way / Barnes Road
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **From OR-217 South**

1. Merge onto OR-217 North
2. Take the Barnes Road exit
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **From OR-217 North**

1. Merge onto OR-217 South
2. Take the Barnes Road exit
3. Keep right at the fork, follow signs for Barnes Road and merge onto SW Baltic Ave
4. Turn right onto SW Barnes Road
5. Take the first right into the drive and another immediate right into the parking lot to end at 9450

### **Trimet Passengers:**

Bus 20 stops near our location and Sunset Transit Center is less than a mile away



Patient Name: \_\_\_\_\_

### DISCLOSURE AND AUTHORIZATION

#### Patient Consent

I am requesting that Somnique Health and the doctors who practice there will test me for possible sleep disorders. I understand that as a patient, I am required to authorize Somnique Health for such services. I am hereby authorizing such tests. I understand that photos, digital video, and other images may be recorded to document my care, and I consent to this. I understand that Somnique Health will retain the ownership rights to the photos, digital video, and other images but that I will be allowed to view them and obtain copies upon my request. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for a time period that is required by law. I have consulted my physician and I understand the tests that I will undergo. By signing this consent, I authorize the Somnique Health staff to perform the tests that are ordered by the physician.

#### Check in policy/Health Coverage Disclosure

Patients are required to provide the front office at time of check-in information pertaining to changes with home address, mailing and current insurance information. **If patients have two policies, the information MUST BE DISCLOSED, as failing to provide information will result in patient liability. Patients ARE NOT TO provide Medicaid as a primary insurance while having commercial insurance through an employer as this will also result in patient liability as we cannot bill government funded insurance as primary over group insurance.** For patients with commercial insurance, presenting a Medicaid card as 2<sup>nd</sup> insurance, **please NOTE: Government funded insurance does not cover deductibles, co-pays, co-insurance, from group insurance and patients are required to notify government funded programs of active coverage through employer/group insurance.**

**\*\*INITIAL** \_\_\_\_\_ Patients are responsible for balance should insurance omission result in non-payment due to lack of referral.

**Medicare patients: When opting for a Medicare replacement plan for your Medicare Part B, the front office cannot accept straight Medicare as a 2<sup>nd</sup> insurance to cover deductible and or co-insurance as once opting for a replacement plan, straight Medicare Part B benefit is terminated and only supplement plans covering co-insurance should be provided as 2<sup>nd</sup> insurance to the front office.**

**\*\*INITIAL** \_\_\_\_\_

**Coordination of benefits information requested by payer from the patient, must be provided promptly as failing to provide insurance with COB will result in patient liability.**

**\*\*INITIAL:** \_\_\_\_\_

**\*\*PATIENT SIGNATURE REQUIRED IN AGREEMENT**

**TO CHECK-IN AND HEALTH COVERAGE DISCLOSURE:** \_\_\_\_\_

#### Receipt of Notice of Privacy Practices and Disclosure, Patient Rights and Responsibility, and Provider Performance Standards

I have reviewed and understand the Privacy Practices, Patient Rights and Responsibility, and Provider Performance Standards. I understand my rights as they are contained in these documents. I authorize the use and disclosure of my health information for the purposes of treatment, determination of benefits, payment, and care as described in the Privacy Practices. This includes any doctors and their staff who provide services for Somnique Health, durable medical equipment company and their staff which will provide me with medical equipment. I authorize Somnique Health to leave voicemails on the phone numbers I have provided to them, and with whoever may answer at those phone numbers. This may include messages that are left at my business.

#### Patient Assignment of Benefit Agreement

I understand that the explanation of benefit from my insurance carrier is not a bill from Somnique Health. I understand that no charges are due from me until I receive a statement from Somnique Health. I understand that if I have billing questions, I can call Somnique Health to provide me with these answers and that they may seek assistance from eCW (their electronic medical records and billing company).

I understand that ultimately, I bear the responsibility for the payment of all fees associated with the procedures provided by Somnique Health. I am responsible for all charges not covered by my insurance carrier and if I receive any payments from my insurance carrier



directly, I will immediately forward such payment to Somnique Health for the services they provided. Services provided may include tele-medicine visits.

I authorize direct remittance of payment of all insurance or Medicare benefits to Somnique Health for all covered services. I understand and agree that this assignment of benefits will have continuing effect for so long as I am being cared for by Somnique Health. I authorize my insurance company to mail all payments directly to Somnique Health.

#### Commercial Drivers

I understand if I am diagnosed with a sleep disorder, the Department of Motor Vehicles may be contacted if I do not follow my doctor's instructions and recommendations, or if I am found to be non-compliant with my treatment.

#### Past Due Accounts

I understand that a fee may be charged on all accounts which are 90 days or more past due at a rate of 1% per month. I understand that the 1% may be added to the account and hereby agree to pay such charges if levied. I also understand that if my account is placed with a collection agency, additional fees with ensue including court costs and those fees will be added to my account balance.

#### Check Acceptance Policy

Checks that are returned to Somnique Health unpaid from your account will be assessed an additional \$35 NSF fee. Returned balance plus additional fee will be required to paid off in the form of cash or credit card. We accept Visa, Mastercard and American Express.

#### Cancellation Policy

I understand that I must provide at least a 24-hour notice to any appointments I am unable to keep. If I do not provide at least a 24-hour notice prior to a cancellation or if I do not show up for a scheduled appointment, I understand that I will be charged a cancellation fee of \$50.00 for clinic visits and \$200.00 for sleep studies.

**I have read and understand all of the above, and my initials and signature represent acceptance and acknowledgement for all of the above. I authorize a copy of this form to be used in place of the original.**

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE



Medical Information Release Form

(HIPAA Release Form)

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Release of Information

\_\_\_\_\_ I authorize the release of the following information including but not limited to: diagnosis, medical records, billing and claims information. This information may be released to the following:

Names: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Information is NOT to be release to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:         my cell         my home         my work

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

Okay to leave a message with anyone in the home

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## Demographic Form

### PATIENT INFORMATION

DATE: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Language: \_\_\_\_\_ Do you need and Interpreter YES NO

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Telephone: ( ) \_\_\_\_\_ Secondary Telephone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

\*Emergency Contact Name: \_\_\_\_\_

\*Relationship: \_\_\_\_\_ \*Emergency Contact Telephone: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group#: \_\_\_\_\_ Subscriber: \_\_\_\_\_

### GUARDIAN INFORMATION (if patient is a minor)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Social Security #: \_\_\_\_\_

Do you reside at the same address? YES NO (if no, address below)

Address: \_\_\_\_\_



**\*Late cancellations and no-show appointments may be charged a \$50 fee**

Pediatric Sleep Questionnaire

Date: \_\_\_\_\_

Name \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Height \_\_\_\_ Weight \_\_\_\_

**HISTORY**

**Briefly describe the problem your child is having with his or her sleep.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check if your child currently has or has had any of the following:**

- |   |   |
|---|---|
| <input type="checkbox"/> Snores loudly.   | <input type="checkbox"/> Excessively sleepy during the day.         |
| <input type="checkbox"/> Snores in all positions.   | <input type="checkbox"/> Excessive daytime fatigue.                 |
| <input type="checkbox"/> Stops breathing at night.  | <input type="checkbox"/> Sudden episodes of sleep during the day.   |
| <input type="checkbox"/> Wakes up gasping for breath.   | <input type="checkbox"/> Sleep walking.                             |
| <input type="checkbox"/> Wakes up coughing or choking.  | <input type="checkbox"/> Bedwetting.                                |
| <input type="checkbox"/> Frequent nightmares.   | <input type="checkbox"/> Difficulty concentrating.                  |
| <input type="checkbox"/> Wakes up screaming.  | <input type="checkbox"/> Wakes up with a sour taste in their mouth. |
| <input type="checkbox"/> Behavioral issues.   | <input type="checkbox"/> Sleep talk.                                |
| <input type="checkbox"/> Hyperactive.   | <input type="checkbox"/> Sleep walk.                                |
| <input type="checkbox"/> Poor grades in school.   | <input type="checkbox"/> Restless sleep.                            |
| <input type="checkbox"/> Currently takes naps during the day.   | <input type="checkbox"/> Kicks or thrashes around at night.         |
| <input type="checkbox"/> Feels sudden physical weakness during strong emotions (such as mouth dropping open or legs going limp during laughter or anger.) | <input type="checkbox"/> Difficulty maintaining sleep at night.     |
|   | <input type="checkbox"/> Frequent awakenings.                       |



## SLEEP SCHEDULE

What time does your child go to bed? \_\_\_\_\_ **Weekday:** \_\_\_\_\_ AM/PM      \_\_\_\_\_ **Weekend:** \_\_\_\_\_ AM/PM  
What time does your child wake up? \_\_\_\_\_ AM/PM      \_\_\_\_\_ AM/PM  
Average amount of sleep per night \_\_\_\_\_ hours      \_\_\_\_\_ hours

Does your child share a bedroom with other siblings? \_\_\_\_\_ Yes      \_\_\_\_\_ No  
Does your child have a TV in the bedroom? \_\_\_\_\_ Yes      \_\_\_\_\_ No

Allergies \_\_\_\_\_

## SYSTEMS REVIEW

Please check if your child currently has or has had any of the following:

### Constitutional

\_\_\_\_\_ Fever    \_\_\_\_\_ Weight gain    \_\_\_\_\_ Weight loss    \_\_\_\_\_ Fatigue    \_\_\_\_\_ Night sweats

### Eyes

\_\_\_\_\_ Pain    \_\_\_\_\_ Redness    \_\_\_\_\_ Loss of vision    \_\_\_\_\_ Double or blurred vision    \_\_\_\_\_ Dryness

### Ears-Nose-Mouth-Throat

\_\_\_\_\_ Hearing loss    \_\_\_\_\_ Nosebleeds    \_\_\_\_\_ Loss of smell    \_\_\_\_\_ Dryness in nose    \_\_\_\_\_ Loss of taste  
\_\_\_\_\_ Sores in mouth    \_\_\_\_\_ Dryness of mouth    \_\_\_\_\_ Hoarseness

### Cardiovascular

\_\_\_\_\_ Chest Pain    \_\_\_\_\_ Irregular heart beat    \_\_\_\_\_ High blood pressure    \_\_\_\_\_ Swollen legs or feet

### Respiratory

\_\_\_\_\_ Shortness of Breath    \_\_\_\_\_ Difficulty breathing at night    \_\_\_\_\_ Cough    \_\_\_\_\_ Coughing up blood  
\_\_\_\_\_ Wheezing

### Gastrointestinal

\_\_\_\_\_ Loss of appetite    \_\_\_\_\_ Nausea    \_\_\_\_\_ Vomiting of blood or "coffee ground" material  
\_\_\_\_\_ Abdominal pain    \_\_\_\_\_ Heartburn/reflux    \_\_\_\_\_ Difficulty swallowing    \_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Constipation    \_\_\_\_\_ Blood in stools    \_\_\_\_\_ Black stool

### Urinary

\_\_\_\_\_ Difficult urination    \_\_\_\_\_ Pain or burning on urination    \_\_\_\_\_ Blood in urine  
\_\_\_\_\_ Discharge from penis/vagina    \_\_\_\_\_ Rash/ulcers

### Musculoskeletal

\_\_\_\_\_ Morning stiffness    \_\_\_\_\_ Joint pain or swelling    \_\_\_\_\_ Muscle weakness    \_\_\_\_\_ Muscle tenderness

### Skin

\_\_\_\_\_ Easy bruising    \_\_\_\_\_ Rashes    \_\_\_\_\_ Sun sensitivity    \_\_\_\_\_ Tightness    \_\_\_\_\_ Nodules/bumps  
\_\_\_\_\_ Hair loss

### Neurological

\_\_\_\_\_ Headaches    \_\_\_\_\_ Dizziness    \_\_\_\_\_ Weakness    \_\_\_\_\_ Memory loss

### Psychiatric

\_\_\_\_\_ Excessive worries    \_\_\_\_\_ Anxiety    \_\_\_\_\_ Easily loses temper    \_\_\_\_\_ Depression    \_\_\_\_\_ Agitation

### Endocrine:

\_\_\_\_\_ Excessive thirst





**Hematologic:**

\_\_\_\_\_ Swollen glands \_\_\_\_\_ Tender glands \_\_\_\_\_ Bleeding tendency \_\_\_\_\_ Anemia \_\_\_\_\_ Transfusions

**SOCIAL HISTORY**

**Please check and answer all of the following:**

Does your child drink coffee, tea, or soft drinks? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, regular \_\_\_\_\_ or decaffeinated \_\_\_\_\_ How much daily? \_\_\_\_\_

How many meals does your child eat daily? 0 1 2 3 4 5

Does your child exercise regularly? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what time of the day? \_\_\_\_\_ Morning \_\_\_\_\_ Mid-day \_\_\_\_\_ Evening

**PAST MEDICAL HISTORY**

Has your child had any surgeries? If yes, what year?

\_\_\_\_\_ Appendectomy \_\_\_\_\_ Ear nose or throat surgery \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

Does your child have any history of the following medical problems? If yes, please mark.

\_\_\_\_\_ Heart disease \_\_\_\_\_ Lung disease \_\_\_\_\_ Diabetes \_\_\_\_\_ Seizure disorder

\_\_\_\_\_ Other (please explain) \_\_\_\_\_

Allergies: \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication list (Please list the name of each medication.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over the counter medications / herbal supplements

\_\_\_\_\_

**IMMEDIATE FAMILY (mother, father, siblings)**

**Person with disorder**

Diabetes \_\_\_\_\_

Heart disease \_\_\_\_\_

High blood pressure \_\_\_\_\_

Stroke \_\_\_\_\_

Obesity \_\_\_\_\_

**Person with disorder**

Snoring \_\_\_\_\_

Sleep Apnea \_\_\_\_\_

Narcolepsy \_\_\_\_\_

Daytime sleepiness \_\_\_\_\_

Other \_\_\_\_\_



Please add any other information you would like us to know that is not covered in this questionnaire.

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How did you choose Somnique Health? Check and explain all that apply.

- Physician \_\_\_\_\_
- On-line \_\_\_\_\_
- Friend \_\_\_\_\_
- Newspaper \_\_\_\_\_
- Radio \_\_\_\_\_
- Other \_\_\_\_\_

Thank you for your time in filling this questionnaire out. It is a valuable tool for the physician.

Please bring this with you to your first appointment. We look forward to meeting you and your child!



## **PATIENT RIGHTS AND RESPONSIBILITIES**

### **As a patient of Somnique Health you have the right:**

- \*To be treated with dignity and compassion and to have your privacy and property to be respected at all times.
- \*To privacy and confidentiality of all records pertaining to your care, except as otherwise provided by law, and to have access to those records upon request.
- \*To receive appropriate care and services in a professional manner without discrimination relative to your age, race, sex, religion, ethnic origin, sexual preference, physical or mental handicap, or personal, cultural, and ethnic preferences and to be free from any mental abuse, physical abuse, neglect, or exploitation of any kind by our staff.
- \*To obtain complete and clear information concerning your diagnosis, your treatment, and your prognosis.
- \*To exercise your rights as a patient, such as providing informed consent, or to have your authorized representative exercise your rights as a patient.
- \*To participate in the development and modification of your care and service plan and to refuse treatment within the boundaries set by law.
- \*To be informed of the services which are available at our facility, who will be providing care, and the fees and charges for such services and products provided.
- \*To be informed of any experimental treatment or research study and to refuse to participate in these projects.
- \*To express concerns, grievances, or recommendations without fear of discrimination or reprisal and to be involved as appropriate in discussions and resolutions of conflict and or ethical issues related to your care. Please report all concerns of grievances to the Clinical Administrator, Erica Cayson at (503) 688-5536.

### **You have the responsibility:**

- \*To keep scheduled appointments, and when unable to do so, notify us immediately.
- \*To be considerate of other patients and staff and to control noise and other distractions while at our facility.
- \*To respect the privacy and property of others and the facility.
- \*To notify your caregivers when you feel ill or if you encounter any unusual physical or mental stress while at our facility.
- \*To provide complete and accurate information concerning your present health, medications, allergies, etc. when appropriate to your care and service.
- \*To notify us of any changes to your health insurance coverage, changes in your address or contact information, or changes in your medical history.
- \*To request additional assistance or information on any phase of your health care plan that you do not fully understand.
- \*To actively participate in decisions about your health care and to comply with treatment recommendations.
- \*To promptly fulfill financial obligations to the facility by making payments when they are due, or by providing documentation or information in order to complete insurance claim filing.



## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you may gain access to this information. Please review it carefully. Somnique Health is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected information.

### Disclosure of your health care information:

- \*Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.
- \*Payment: We may disclose your health care information to your insurance provider for the purpose of payment or healthcare operations. If payment is not made as arranged, our office may utilize an outside collection agency or other means of collecting an outstanding debt. Your file containing protected health care information may be reviewed by the designated collection agency or authority.
- \*Workers compensation: If applicable we may disclose your health care information as necessary to comply with the Workers Compensation Laws.
- \*Public Health: As required by law, we may disclose your health care information to public health authorities for purposes related to: preventing or controlling a disease, injury, disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reactions to medication, and reporting disease or infection exposure.
- \*Emergencies: We may disclose your health care information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in an emergency or of your death.
- \*Judicial and Administrative Proceedings: We may disclose your health care information in the course of any judicial or administrative proceeding.
- \*Public Safety: It may be necessary to disclose your health care information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- \*Law Enforcement: We may disclose your health care information to a law enforcement official for purposes such as locating or identifying a suspect, fugitive, material witness, or missing person, complying with a court ordered subpoena, and any law enforcement purposes.
- \*Deceased Persons: We may disclose your health care information to a coroner or medical examiner.
- \*Organ Donation and Research: We may disclose your health care information to organizations involved in procuring, banking, or transporting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board.
- \*Specialized Government Agencies: We may disclose your health care information for military, national security, prisoner, and government benefits purposes.
- \*Change of Ownership: In the event that Somnique Health is sold or merged with another organization, your health care information will become the property of the new owner.

### Your Health Information Rights:

- \*You have the right to request restrictions on certain uses and disclosures of your health care information. Please be advised however, that Somnique Health is not required to agree to the restriction you requested.
- \*You have the right to have your health care information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request.
- \*You have the right to inspect or copy your health care information.
- \*You have the right to request that Somnique Health amend your protected health care information. Please be advised however, that Somnique Health is not required to agree to amend your protected health care information. If your request has been denied, you will be provided with an explanation of our denial and information on how you can disagree with the denial.
- \*You have the right to receive an accounting of disclosures of your protected health care information made by Somnique Health.
- \*You have the right to a paper copy of this Notice of Privacy Practices at the time of your request.

### Changes to this Notice of Privacy Practice:

Somnique Health reserves the right to amend this Notice of Privacy Practice at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Somnique Health is required to comply with this notice. Somnique Health is required by law to maintain the privacy of your health care information and to provide you with notice of its legal duties and privacy practices with respect to your health care information. If you have any questions about this part of the notice, or if you want more information about your privacy rights, please contact us at (503) 688-5536. If no one is available you may leave a message and your call will be returned within 2 business days.

### Complaints

Complaints about your privacy rights or how Somnique Health has handled your health care information should be directed to Somnique Health at (503) 688-5536. If no one is available you may leave a message and your call will be returned within 2 business days. If you are not satisfied with the manner in which your complaint was handled, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave SW, Room 509F, HHH Building, Washington, DC 20201.