New Patient Registration Form

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth / Age	Social Security #	Driver's License #
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Spouse's Name (If Applicable)	Email	
Employer Name	Employer Address		
Primary Care Physician Name	Phone #	Referring Physician Name	Phone #
Race (optional) ☐ White ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Hawaiian ☐ Declined	Ethnicity (optional) ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined	Primary Language	

Complete this section only if the patient is a minor

Responsible Party

Responsible Party Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)	City	State	Zip
Home Phone #	Work Phone #	Cell Phone #	
Sex (check one) ☐ Male ☐ Female	Date of Birth / Age	Social Security #	Driver's License #

Insurance

PRIMARY Insurance Company	Effective Date	**SECONDARY** Insurance Company	Effective Date
Policy Holder (if other than patient)	DOB	Policy Holder (if other than patient)	DOB
Policy Holder Social Security #	Relationship to Patient	Policy Holder Social Security #	Relationship to Patient

Financial Responsibility

I hereby authorize payment of medical benefits directly to *Colorado Pulmonary Intensivists, PC* and/or the physician or nurse practioner for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patients' medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to CPI. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of CPI, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____
Patient Name (please print)

_____ _____ _____
Signature of Patient, Parent, or Legal Guardian Date

Colorado Pulmonary Intensivists
Privacy Policy Acknowledgment & CORHIO Authorization

HIE Exchange Consent

Electronic Health Information Exchange

Colorado Pulmonary Intensivists endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of test and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE or cancel an opt-out choice, at any time.

I would like to participate in the CORHIO HIE (described above). I understand that I can opt-out or cancel at any time.

_____

Print Name

_____ _____

Patient (or Patient Representative) Signature Date

Privacy Practices

Acknowledgment of Receipt of the CPI Notice of Privacy Practices:

I acknowledge that I have received the Notice of Privacy Practices ("The Notice") for the practice of Colorado Pulmonary Intensivists, P.C.

_____ _____ _____

Print Name Patient (or Patient Representative**) Signature Date

**If Patient Representative, legal documentation must be included to show authority to sign or receive information.

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____

Approved HIPPA Contacts

Whom may we disclose healthcare info to on your behalf?

I DO consent CPI to leave detailed messages as follows: ☐ **Do not speak with anyone**

I, _____, give Colorado Pulmonary Intensivists, PC and the staff my permission to leave messages regarding my medical care with the following (This will remain in effect until you change it in writing):

Home Phone _____ Initials _____

Cell Phone _____ Initials _____

My spouse _____ Initials _____

Family or Other _____ Initials _____

Emergency

Emergency Contact Information:

Emergency Contact Name _____ Relationship to patient _____

Emergency Contact Phone Number _____

COLORADO PULMONARY INTENSIVISTS, PC

QUALIFYING SLEEP STUDY QUESTIONNAIRE

Date: _____ Referring MD: _____ Phone: _____

Name: _____ ☐ Male ☐ Female Age: _____

Weight: _____ Height: _____ Were you previously diagnosed with sleep apnea? ☐ Yes ☐ No

Were you previously treated for sleep apnea? ☐ Yes ☐ No CPAP? ☐ Yes ☐ No If yes, CPAP Level? _____cm

UPPP/Surgery? ☐ Yes ☐ No If yes, why is this study being done / needed? _____

Usual time you go to bed: _____ Usual time up in the morning: _____

One a scale of 0 to 10, how sleepy are you during the day? ___ On a scale of 0 to 10, how fatigued are you during he day?___

Do you snore loudly? ☐ Yes ☐ No How many nights weekly do you snore? _____

Do you kick your legs when you sleep? ☐ Yes ☐ No

Do you feel discomfort or an overwhelming need to move your legs when stationary? ☐ Yes ☐ No

Do you walk or talk in your sleep ☐ Yes ☐ No Do you wake up startled or gasping for breath? ☐ Yes ☐ No

Have you been told you stop breathing in your sleep? ☐ Yes ☐ No Do you wake up with headaches? ☐ Yes ☐ No

Do you currently use oxygen? ☐ Yes ☐ No If yes, what is the oxygen flow rate (LPM): _____

Do you use a walker / wheelchair / cane or have any other disability? _____

Do you have a family history of sleep problems? ☐ Yes ☐ No What is the altitude of your home? _____ ft.

Do you have any of the following medical conditions:

- ☐ COPD
- ☐ Asthma
- ☐ Chronic Rhinosinusitis
- ☐ Pulmonary hypertension
- ☐ Arthritis
- ☐ Collagagen Vascular Disease
- ☐ Fibromyalgia
- ☐ Other medical problems: _____
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Gastroesophageal Reflux (GERD)
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Depression /Anxiety

Cardiac Problems:

- ☐ Hypertension
- ☐ Previous Myocardial Infarction
- ☐ Previous Bypass or PTCA / Stent
- ☐ Congestive Heart Failure
- ☐ Cardiac Dysrhythmia
- ☐ Pacemaker
- ☐ Congenital Heart Defect
- ☐ Valvular Heart Disease

List of Medication(s): _____

_____

Allergies to medication(s): _____

Daily Intake:

Caffeine (coffee / tea / soda and cups, glasses per day): _____

Nicotine (smoked packs per day / chewed can or pouch per day): _____

Alcohol (wine / beer / liquor and cups, glasses per day): _____

*Times you drink alcohol (afternoon, dinner /evening/before bed): _____

Next of kin, Emergency contact (Name and number): _____

Sleep Physician: _____ Date: _____

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SLEEP CENTER

Name: _____ SSN: _____

Address: _____ City: _____ State: ___ Zip: _____

Home phone: _____ Work phone: _____ Cell/pager: _____

Occupation: _____ Marital Status: _____

Birth date: _____ Age: _____ Height: _____ Weight: _____ Sex: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Regular Physician (if different than above) _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Describe your chief complaints (What is the nature of your sleep problem? What makes it better or worse?):

_____

_____

How long has it been present? _____

What prompted you to seek help now? _____

How serious is this problem to you? (Circle one) Very serious Somewhat serious Not serious at all

Have you ever been evaluated at a Sleep Disorders Center? _____

	Weekdays	Weekends
What time do you get into bed?	_____	_____
When do you fall asleep?	_____	_____
When do you wake up?	_____	_____
When do you get out of bed?	_____	_____

How long does it take for you to fall asleep? _____

How many hours of sleep do you normally get? _____

How many hours of sleep do you need to feel well rested? _____

How many times each night do you get up? _____

What wakes you up? _____

How long does it take you to go back to sleep after awakening? _____

What wakes you up? (Circle one) Wake spontaneously Alarm clock Other

What time do you go to work? _____

How do you feel when you get up? (Circle one) Alert and rested Somewhat sluggish Groggy

How long does it take you to "get going"? (Circle one)

A few minutes About 30 minutes Longer than 1 hour

Do you have any aches or pains when you wake up? (Please describe) _____

_____

How do you feel during the day? _____

What is your best time of the day? (Time when you are most alert) _____

What is your worst time of the day? (Time when you are the least alert) _____

Do you take naps? (Circle one) Yes No

If yes, please describe the time of day and the length of these naps: _____

_____

How frequently do you take naps? (Circle one)

More than once a day At least once a day A few days a week Rarely

How do you feel after taking a nap? (Circle one)

Very refreshed Somewhat refreshed Somewhat tired Very drowsy

Have you ever had a sudden, overpowering, irresistible "attack of sleepiness"? (Circle one) Yes No

If yes, please describe how frequently this occurs and in what situation(s) _____

_____

Can you fight off an "attack of sleepiness"? (Circle one) Yes No

If so, how _____

_____

Do you have any problem staying awake while driving an automobile? (Circle one) Yes No

Have you actually fallen asleep at the wheel? (Circle one) Yes No

Do you have any problems with daytime fatigue (as opposed to sleepiness)? (Circle one) Yes No

Do you snore? (Circle one) Yes No

Have you ever been told that you stop breathing or hold your breath while you are sleeping? (Circle one)

Yes No

Are you an active sleeper (awaken to find your bedclothes and sheets in disarray)? (Circle one) Yes No

Do you sweat a lot at night? (Circle one) Yes No

Do you wake up gasping, choking or feeling short of breath? (Circle one) Yes No

Does your snoring bother others? (Circle one) Yes No

Do you ever lose muscle strength when you laugh, get very excited, angry, happy or sad? (Examples are weakness in knees, or sagging facial muscles or, in extreme cases, total collapse). (Circle one) Yes No

Do you ever feel paralyzed (can't move) as you go to sleep or wake up? (Circle one) Yes No

Do you ever see or hear things that you don't think are real as you go to sleep or awaken? (Circle one) Yes No

Do any of your family members have the symptoms listed in the last three questions? (Circle one) Yes No

Do you have unpleasant sensations in your legs? (Circle one) Yes No

If yes, please describe the sensations and anything you do to relieve them: _____

_____

_____

Have you ever been told that you kick in your sleep? (Circle one) Yes No

Does this wake you up? (Circle one) Yes No

If you have difficulties falling asleep at night, circle the items listed below which you feel contribute toward your inability to quickly fall asleep:

a. have thoughts racing through your mind
b. feel sad and depressed
c. have anxiety (worry about things that you should or should not do)
d. feel muscular tension, if so, where:
e. feel afraid of not being able to fall asleep
f. feel unable to move as though you were paralyzed
g. notice that parts of your body twitch or jerk
h. experience a crawling aching or creeping sensation in your legs preventing you from staying still
i. experience vivid dreamlike images or other visual or auditory hallucinations
j. experience any kind of pain or physical discomfort. If so, what kinds and where: _____

_____

k. sleeping conditions too light
l. sleeping conditions too dark
m. sleeping conditions too noisy
n. sleeping conditions too quiet
o. sleeping conditions too cool
p. sleeping conditions too warm

MEDICAL HISTORY

Are you generally in good health so far as you know? (Circle one) Yes No

Has your weight changed in the last 12 months? (Circle one) Yes No

If yes, how many pounds have you gained or lost? _____

Do you now smoke? (Circle one) Yes No

If no, but you have smoked, how long ago did you stop? _____

For how long did (have) you smoke (d)? _____

How many cigarettes, cigars, or pipefuls of tobacco did (do) you use daily? _____

(Circle type of usage)

List the amounts of the following beverages you consume. If not used every day, list in the far right column the average per week:

	Daily	After 6 pm	At bedtime	Weekly
Caffeinated coffee (cups)	_____	_____	_____	_____
Caffeinated Tea (glasses or cups)	_____	_____	_____	_____
Caffeinated carbonated drinks (cans/bottles)	_____	_____	_____	_____
Beer, wine, liquor (cans/bottles)	_____	_____	_____	_____

List all medications (prescribed or non-prescribed) that you have ever taken for your sleep problem:

	Dose	Times daily	Helpful	How long used	Use it now	When stopped	Prescribing MD
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____

In addition to the medicines listed above, name all other medications (prescribed or otherwise) taken during the past 2 years on a regular or frequent basis:

	Dose	Times daily	Helpful	How long used	Use it now	When stopped	Prescribing MD
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____

Medications continued…

_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____
_____	____	____	_____	_____	_____	_____	_____

List the health problems you have had:

System	Type of problem	Date	Treating Physician, Clinic, or Hospital
Respiratory conditions:	_____	_____	_____
Psychological conditions:	_____	_____	_____
Eyes, ears, throat/mouth:	_____	_____	_____
Nasal (e.g., sinus, congestion, allergies):	_____	_____	_____
Heart, circulation, blood pressure:	_____	_____	_____
Stomach, digestive, or intestinal disorders:	_____	_____	_____
Kidney, urological or sexual disorders:	_____	_____	_____
Head/nervous system (e.g., head trauma, convulsions):	_____	_____	_____
Surgical operations (e.g., nasal surgery, tonsillectomy, hysterectomy, etc.):	_____	_____	_____
Other conditions (e.g., painful conditions, hormone abnormalities, diabetes, thyroid, etc.):	_____	_____	_____

Have you, in childhood or currently, ever experienced any of the following phenomena during sleep? If so, put a check mark to the left of those you have experienced and circle the specific items. Also, please complete the information in the columns. (Check all that apply)

	Times/Week	Age it began	Last occurred	Treatment, if any
___ talking when apparently asleep	_____	_____	_____	_____
___ sleepwalking	_____	_____	_____	_____
___ grinding teeth when asleep	_____	_____	_____	_____
___ bedwetting	_____	_____	_____	_____
___ recurrent dreams	_____	_____	_____	_____
___ disturbing dreams	_____	_____	_____	_____
___ waking with sour or acid taste	_____	_____	_____	_____
___ waking up screaming and afraid in the first 3 hours of sleep	_____	_____	_____	_____
___ chest pain, wheezing, rapid or irregular heart beat during sleep	_____	_____	_____	_____
___ unusual movements when apparently asleep	_____	_____	_____	_____
___ awakening from sleep with headaches; heavy perspiration	_____	_____	_____	_____
___ (Males) painful erections that awaken you from sleep	_____	_____	_____	_____

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FAMILY SLEEP PROBLEMS

Has anyone in your family ever had a sleeping problem, daytime sleepiness, or snoring? If so, please complete the items below for affected family members.

Family member	Type of problem	Suggested Treatment	Treating Physician Clinic or Hospital	When treated if ever (year)

Family health history: For each family member, indicate current age or age at death, present state of health (good, poor) or cause of death, as well as major illnesses. Print the names of all relatives in the space to the left.

	If living		If deceased		
Relationship/Name	**Age**	**Health**	**Age**	**Cause**	**Medical problems/Illnesses**

Notice of Privacy Practices for Protected Health Information (PHI)

Colorado Pulmonary Intensivists P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: August 1, 2013

The Practice of Colorado Pulmonary Intensivists P.C. is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances

- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (303) 952-1100, or in writing to us at:

Dawn Holdren
Colorado Pulmonary Intensivists P.C.
15 West Dry Creek Circle
Littleton, CO 80120

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.