**Perry Center for Pediatric and Adult Sleep Care**

Gayln V. Perry, MD LLC

12641 Antioch Rd #114

Overland Park, KS 66213-1701

913-354-4948 (office) [info@sleepdockc.com](mailto:info@sleepdockc.com)

**COVID CARE PATIENT INFORMATION**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

Care Level Requested:

\_\_\_ Prophylaxis: Includes consultation, education, prescriptions: $75.

\_\_\_ I’m sick now: If less than 40 years old and no risk factors. Includes consultation, education, prescriptions and management of acute phase of disease. $150. ($50 if Prophylaxis was provided earlier.)

\_\_\_ I’m sick now: If greater than 40 years old with risk factors. Includes consultation, education, prescriptions, and management of acute phase. $200. ($100 if Prophylaxis was provided earlier.)

\_\_\_ I’m STILL sick: Lingering post-Covid symptoms can be complex and require ongoing treatment. Symptoms may include: brain fog, fatigue, shortness of breath, rapid heart rate, joint aches. Includes consultation, education and prescriptions. $150/session.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(last)

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/year)

Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy. *(If your pharmacy is unwilling to fill the prescription, we suggest a compounding pharmacy or one of the following: Queen’s Price Chopper (151 & Metcalf), Ken’s Sunflower Pharmacy (Old Overland Park), Phillips Pharmacy (Riverside), Lewisburg Vohs Pharmacy, Dillon’s Central and 105th Wichita).* \*\* You need to purchase an Oximeter (instructions below) and a thermometer. A Nebulizer is optional. \*\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Your pharmacy name and phone)

**Health Summary**

**Current Weight: \_\_\_\_\_\_\_\_** lbs.

**Oximeter and Thermometer Readings:** For prophylactic consultation, please provide the measurements below for one day. If you are being treated, you will need to do this for five days in a row and send the results to Dr. Perry at the email above.

Date: Date: Date: Date: Date: Date: Date: Date: Date:

Pulse (morning) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Oxygen (morning) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Temperature “ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Pulse (evening) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Oxygen (evening) \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Temperature “ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

\* TIPS for Oximeter use: Do not take your oximeter reading first thing in the morning or while still in bed. Get up, walk around, and take deep breaths. Readings are most accurate when sitting still and not moving hands or arms. The heartbeat signal must be consistently beating to indicate the signal is strong. The trend of readings has more value than a single reading—hence the 5-day is helpful.

**Have you had a COVID-19 Injection (vaccine)?** \_\_\_ Yes or \_\_\_ No If yes, which injection (vaccine) did you have? Manufacturer (J&J, Pfizer, or Moderna) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total number of shots taken \_\_\_\_\_\_. Date of most recent injection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/year)

**Smoker:** (check 1) \_\_\_\_\_ Yes \_\_\_\_\_ Yes, but in the past \_\_\_\_\_ No, I never smoked

**Allergies:** (list all).

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**Medications:** List all medications (name and dose) that you are currently using including birth control or hormones:

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**Supplements:** List all supplements you are currently using and their dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you sick now?** Describe how the symptoms initially presented and how symptoms progressed (nausea, cough, sore throat, diarrhea, loss of taste, loss of smell, shortness of breath, heart palpitations, fatigue, headache as an example):

Date symptoms began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Symptom progression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**List All Medical Conditions** or surgeries you have or have had:

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**Blood Clotting:** Have you or anyone in your family ever had a blood clot? \_\_\_ Yes \_\_\_ No

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**INFORMED CONSENT for PATIENT INFORMATION**

**Initial All Below**

\_\_\_ I acknowledge that I have read the accompanying Practice Policies.

\_\_\_ I acknowledge that there is no approved FDA outpatient treatment for COVID. I want to have access to treatments that are off-label (FDA approved medications for other diseases). I want the right to try to treat my Covid-19 infection as early as possible to avoid possible worsening and progression of disease.

\_\_\_ I agree to have my medical records accessible to Dr. Perry. These records will be kept private.

\_\_\_ I agree, in the event I become worse, to contact Dr. Perry immediately. “Worse” means increase in cough, shortness of breath, slow decline in oxygen saturation, change in mental status or increasing fatigue or weakness.

\_\_\_ I agree to go to the ER If I have difficulty breathing or my oxygen level is 90% or below.

\_\_\_ I acknowledge that I may still get Covid and/or require hospitalization.

\_\_\_ I agree to hold Dr. Perry harmless in all manner.

**SEND COMPLETED FORMS VIA EMAIL:** [info@sleepdockc.com](mailto:info@sleepdockc.com) \*\* RECEIPT AND REVIEW OF THIS FORM AND THE PRACTICE POLICIES IS NEEDED PRIOR TO TREATMENT. \*\*

**PLEASE SEND CHECKS:** The advice and treatment offered by Dr. Gayln Perry is simply to help as many people as she can. Please send check to Dr. Gayln Perry, MD LLC, 12641 Antioch Road #114, Overland Park, KS 66213-1701.

**PLEASE SIGN YOUR NAME HERE:**

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

Printed Name Signature (typed name represents Date

signature if submitted electronically)

PLEASE COMPLETE THE FOLLOWING TWO FORMS:

* CONSENT FOR NON-SECURE ELECTRONIC COMMUNICATIONS
* NOTICE OF PRIVACY PRACTICES

**Perry Center for Pediatric and Adult Sleep Care**

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Policy: **Consent for Non-Secure Electronic Communication**

Please read carefully. This form discusses the risks of using emails and text messaging to share personal health information.

* Electronic communication, via email and text, between you the Perry Center are not encrypted and may not be secure.
* Third parties may be able to intercept, read, alter, forward or use health information transmitted by email or text without authorization or detection by you or the Perry Center.
* An un-secure message may be accidentally forward to unintended recipients.
* Information shared by email may be printed, copied, and stored by any recipient. Copies of email messages containing personal health information may be kept, for example on backup servers or hard drives, long after the original message is deleted by both the sender and the recipient.
* Your personal information in Perry Center records may include information relating to prescriptions and medications, communicable diseases, physical impairment, chronic conditions, genetics, behavioral and mental health services, alcohol and drug abuse or addiction, billing and payments, and other information related to your medical care and condition.

***I give permission for my physician to contact me using non-secure methods regarding reminders, scheduling, or other relevant matters, and I understand the risks involved:***

Text communication Yes ( ) No ( ) Email communication Yes ( ) No ( )

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Policy: **NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you (as a patient/client of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. Review this carefully.

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

We realize that these laws are complicated, but we must provide you with the following important information:

* How we may use and disclose your IIHI
* Your privacy rights in your IIHI
* Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that are practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

Effective date of this notice: February 1st 2022.

**B. Questions**. If you have questions about this Notice, please contact: Perry Center for Pediatric and Adult Sleep Care, Attn: Office Manager, 12641 Antioch Road #114, Overland Park, KS 66213-1701.

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

**- Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have a laboratory test (such as blood or urine test), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice, including, but not limited to, are doctors and nurses, may use or disclose your IHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IHI to others who may assist in your care, such as your spouse, children or parents.

- **Health Care Providers.** We may disclose your IIHI to outside providers you have sought care from in order to provide the best continuity of care possible. This is especially true in an emergency situation.

**- Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the service and items you may receive from us. If at some point our practice begins to accept insurance, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. Also, we may use your IIHI to bill you directly for services and items provided.

**- Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost- management and business planning activities for our practice.

**- Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment (see separate Electronic Communication policy).

**- Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

**- Health-Related Benefits and Services.** Our practice may use and disclose your IHI to inform you of health-related benefits or services that may be of interest to you.

**- Release of Information to Family/Friends**. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter bring their child to the office for treatment for a cold. In this example, the babysitter may have access to the child’s medical information.

**- Disclosure Required by Law**. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

**D. Your rights regarding your IIHI.** You have the following rights regarding the IIHI that we maintain about you:

**- Confidential communications.** You have the right to request that our practice communication with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to our practice at the address above. Your request must specify the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

**- Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our offices. Your request must describe in a clear concise fashion:

* + the information you wish restricted;
  + whether you are requesting to limit our practices use, disclosure or both; and
  + to whom you want the limits to apply.

**- Inspection and copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient/client medical records and billing records. You must submit your request in writing to our office.

**- Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment your request must be made in writing and submitting to our office manager at the address above. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request, and the reason supporting your request, in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not available to amend the information.

**Accounting of Disclosures.** All of our patients/clients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes, use your IIHI as part of the routine patient/ client care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our practice. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before February 1st 2022. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists requested within the same 12- month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**- Right to Paper Copy of This Notice.** You are entitled to a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time to obtain a paper copy of this notice contact our office address given above.

**- Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office manager at the address above. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**- Right to Provide an Authorization for Other Uses and Disclosures.** Our practices will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your I hi may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to obtain records for your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact our office manager at the address above. For further information

**Acknowledgment**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this offices’ Notice of Privacy Practices.

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Printed Name Signature (typed name represents Date

signature if submitted electronically)