Apnix Sleep Diagnostics

The Houston Sleep Center

HST Device Use Agreement

HST DEVICE MUST BE RETURNED IN ACCEPTABLE CONDITION

Patient Name: _____

I understand that I am receiving a medical device for home use and that Apnix Sleep Diagnostics remains the owner of the device at all times during the permitted use of the device. **Prior to use, I will:**

1. **Replace the batteries** in the ApneaLink device with new batteries sent with the unit. The batteries currently in the device are for demonstration purposes only. The new batteries are for testing and only last one test cycle.
2. **View the instructional video** on device usage and **read documentation included** with the device:
    - Review the ApneaLink Air YouTube video.
    - Review the step-by-step instructions included in the device bag.

I agree to return the HST device to the agreed location within 1 business day of receiving the device. I understand that my test results must be interpreted from the device data, so immediate return is important for my diagnosis and for testing other patients. **I agree to use the testing device on the night that I receive it, and I will handle the device with the utmost care. The device is not drip or splash proof or water tight; during use of the device, I will avoid all unnecessary contact with moisture.**

I understand that I am personally liable for the return of the HST device that is being used at my home. I agree that I will be responsible for the replacement cost of the HST device, or cost of repairs, if it is stolen, misplaced, or damaged due to abuse or failure to exercise reasonable care. I agree to use the device only in the manner for which it is intended and not to attempt to make any repairs of any kind. In the event the device becomes inoperable, Apnix Sleep Diagnostics is to be notified at once.

If an emergency makes it impossible to return the device on the agreed date, I understand that I must call Apnix Sleep Diagnostics administrative offices at **(713) 349-9767** to arrange a suitable alternative return date. If I fail to return the equipment to Apnix Sleep Diagnostics **after 5 days**, Apnix may be forced to seek legal recourse, and I agree to pay reasonable attorney's fees if required to ensure the return or replacement of the device.

I agree to pay a **$250.00 cancellation fee** if I fail to use the device or the test is cancelled for any reason after the device has been provided to me. **If I fail to return the device on the agreed date, I agree to pay a $1550 fee** (as Apnix may be prevented from providing the equipment to others on a scheduled date). I understand and agree not to return the HST device to any other location, department, person, or health provider, except as set forth by this agreement.

By signing below, I understand and fully agree with the terms and conditions of this agreement.

Signature of Patient or Patient's Agent or Representative Date

Relationship to Patient

General Conditions of Treatment

THIS AGREEMENT, effective _____ (date) and made this day by and between _____ ("patient") and **APNIX** ("provider"), WITNESSETH:

FINANCIAL AGREEMENT. The undersigned agrees, where s/he signs as agent or as patient, that in consideration of the services to be rendered to the patient, s/he hereby individually obliges her/himself to pay the account of the provider in accordance with the regular rates and terms of the provider. Should the account be referred to an agency for collection, the undersigned shall pay reasonable collection fees and expenses. All delinquent accounts are subject to bear interest at the legal rate.

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO RELEASE INFORMATION. In consideration of services rendered, I hereby transfer and assign to the provider and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance. I further assign all right to payment due me for medical services under said policies to provider, my attending physician, consulting physician, professional laboratory and pathological services. I understand I am financially responsible for the above provider's services. I authorize the provider and/or physicians indicated above to release medical information about me as may be necessary for the completion of my insurance claims for this occasion of service to any insurance carrier, Health or Hospital Plan.

MEDICARE PAYMENTS. (Patient's Certification, Authorization to Release Information and Payment Request) I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this of a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

PERSONAL VALUABLES AUTHORIZATION. I have been informed and understand that the provider *will not assume responsibility* for any personal property I may bring and/or keep in the facility during my stay.

ACCIDENTAL EXPOSURE TO HEALTHCARE WORKER. I UNDERSTAND AND ACKNOWLEDGE THAT Texas Law provides that if any healthcare worker is exposed to my blood or other bodily fluid, the provider may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, Human Immunodeficiency Virus (the causative agent of AIDS) and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of the provider and that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

NOTICY OF PRIVACY/PATIENT RIGHTS & RESPONSIBILITIES/ADVANCED DIRECTIVES. I have been given written material about HIPAA Notice of Privacy Practices. I also acknowledge receipt of a written statement regarding my rights and responsibilities as patient, which tells me how to register any complaint I might have. I have been given written materials about my right to accept or refuse medical treatments and I have been informed of my rights to formulate Advanced Medical Directives.

AUTHORIZATION FOR VIDEO MONITORING AND PHOTOGRAPH. For on site interactions, I hereby authorize the provider to monitor my treatment as is necessary via video camera and video monitor and to record the session on videotape for the purpose of diagnostic observation of the treatment that has been ordered by my physician. Video monitoring may be used for security and training purposes as authorized In addition, I authorize the provider to take still photographs of the patient for the purpose of display on the clinical documentation or results as is necessary.

THE UNDERSIGNED CERTIFIED THAT S/HE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPTS ITS TERMS.

Signature of Patient or Patient's Agent or Representative Date

Relationship to Patient

Apnix Sleep Diagnostics

The Houston Sleep Center

Diagnostics Financial Policy

Patient Name: _____

Definitions:

Deductible: An annual amount you must pay before your insurance begins to pay.
Coinsurance: A fixed percentage of the allowable amount that the patient is responsible for paying on covered expenses. This amount is usually *applied* to the out-of-pocket expense maximum.
Copay: A fixed amount that the patient pays each time they receive covered services. This amount usually *does not apply* to the out-of-pocket expense maximum.
Out-of-pocket Expense Maximum: A fixed amount that the patient is responsible for paying on covered expenses. This amount is usually a sum of network coinsurance payments.

Please be advised that any amount we may or may not collect from you at the time of services is based on information obtained from your insurance company(ies) at the time of verification of benefits. The final determination of patient responsibility is made by your insurance company when the claim is processed and your portion due will be shown on the Explanation of Benefits (EOB) issued by your insurance company. Please notify us immediately, with a minimum of 48 hours prior to your appointment, if you have any changes in your insurance. Presenting new insurance at the time of your service may result in your responsibility for the full billed charge.

Cancellation and No Show Fees for In-Lab Studies

If you need to cancel your appointment, please call Apnix as soon as possible. You must speak with a staff member on the phone. **DO NOT LEAVE A MESSAGE. Call (713) 349-9767 during business hours.** A **no show fee of $250.00** may apply if you do not call ahead to cancel at least 2 business days (or 36 hours) prior to your study. For your study we have assigned a highly-trained technologist to be present for a total of 12 hours. It is very costly to our organization if we have to send this person home. A number of patients are waiting to get in for testing, your unused appointment could have been given to someone else. If you are not at the Sleep Center by 45 minutes after your scheduled time and have not notified us, you will be marked as a no-show and charged the **no show fee of $250.00**.

Cancellation and Replacement Fees for Home Sleep Testing (HST)

If you need to cancel your appointment, please call Apnix as soon as possible. You must speak with a staff member on the phone. **DO NOT LEAVE A MESSAGE. Call (713) 349-9767 during business hours.** A **cancellation fee of $250.00** may apply if you fail to use the device or the test is cancelled for any reason after the device has been provided to the patient. If the device is not returned by the agreed date, the patient will be charged a **$1550.00 fee for replacement** of the HST device.

Sleep Study Interpretation Fees

In addition to the technical charge for the sleep test, there will be an additional charge for the professional portion (interpretation) of the test. This additional charge will also be billed to your insurance(s) on file. The patient will be responsible for any amount applied to deductible, copay, or coinsurance for the interpretation.

I have read and understand the financial policy of Apnix. I also understand that I am responsible for all amounts applied to my deductible, copay, or coinsurance.

Signature of Patient or Patient's Agent or Representative Date

Relationship to Patient

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Apnix Sleep Diagnostics to disclose my individually identifiable health information as described below.

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that this letter will authorize Apnix Sleep Diagnostics to provide a copy, summary, or narrative of my medical record, including any information that may be related to the services conducted at Apnix Sleep Diagnostics, including any medical records sent by your physician, to the following but not limited;

Your insurance company if they seek medical records to process your services towards your benefits
The interpretating physician/practice, who will interpt your sleep study data
Your physician or medical provider of your choosing
Any family members you have choose to Authorize/Disclose your medical records

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying, in writing, Apnix Sleep Diagnostics facility where this authorization is being signed.

I also understand the revocation must be signed and dated with a date that is later than
the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request. A copy of this authorization can be given to me as it is my right.

By signing my name below, I certify that this information can be used for the purpose of processing my Authorization for Release of Information request.

Signature of Patient or Legal Representative | Date

Printed Name of Patient or Legal Representative | Relationship to Patient

Please notify us at the above numbers if this transmission does not arrive properly
"The Next Generation in Sleep Apnea Management"

Patient Demographics

Patient Full Name: / / □ M □ F

First *Middle* *Last* *Suffix* *Date of Birth* *Gender*

Emergency Contact:

Full Name *Phone Number* *Relationship*

Patient Limitations or Special Needs:

Preferred Contact Method: □ Phone □ Text □ Email **Primary Language:** □ English □ Spanish □ Other:

Home / Work / Cell

Home Phone *Work Phone* *Cell Phone* *Circle Preferred*

Email Address:

Home Assessment: □ House □ Apartment □ Private Group Home □Nursing Home □ In-patient Facility

Physical Address:

Street (No PO Boxes) *City* *State* *Zip Code*

Mailing Address: □ *Same as Physical*

Street/PO Box *City* *State* *Zip Code*

Responsibly Party: / / □ **Self** □ **Other:**

(Guarantor) *Full Name* *Date of Birth* *Phone Number* *Relationship*

#1 Primary Insurance:

Insurance Name *Policy #/Member ID* *Group#*

Claims Address/PO Box *City* *State* *Zip* *Insurance Phone*

/ /

Subscriber Full Name *Date of Birth* *Phone Number* *Employer*

#2 Secondary Insurance:

Insurance Name *Policy #/Member ID* *Group#*

Claims Address/PO Box *City* *State* *Zip* *Insurance Phone*

/ /

Subscriber Full Name *Date of Birth* *Phone Number* *Employer*

The information on this form is true to the best of my knowledge. I authorize the release of information required to process my claims/orders.

Signature of Patient or Patient's Agent or Representative

Date

Apnix Sleep Diagnostics
The Houston Sleep Center

Patient Sleep History Questionnaire

If this is someone other than the patient filling out this form, please indicate your name and relationship to the patient: _____

Patient Profile

Date Completed: _____ ☐ Male ☐ Female

Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Age: _____ Height: _____ Weight: _____ Neck or collar size: _____

Occupation: _____ ☐ Shift work ☐ Unemployed ☐ Student

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

What is your primary sleep complaint? _____

Epworth Sleepiness Scale (ESS)

Indicate One: ☐ Pre-CPAP ☐ Post-CPAP

Chance of Dozing:	0 = would never doze, 1 = slight chance, 2 = moderate chance, 3 = high chance			
Sitting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching Television	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (i.e. meeting or movie theatre)	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after lunch (when you've had no alcohol)	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped in traffic	☐ 0	☐ 1	☐ 2	☐ 3

Total Epworth Sleepiness Score: _____

Patient Sleep History Questionnaire

How would you rate your overall daytime sleepiness? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Have you had a sleep study or home apnea screening before? ☐ Yes ☐ No

How long ago? ☐ This year ☐ Last year ☐ 2-5 years ago ☐ 6-10 years ago ☐ 10+ years

Where was the study done? _____

Do you drink alcohol? How much? _____ per ☐ day ☐ week ☐ month ☐ *None*

Do you use tobacco products (smoke, snuff, etc.)? How much? _____ per ☐ day ☐ week ☐ month ☐ *None*

What time do you go to bed? Weekdays: _____ Weekends: _____

What time do you usually wake up? Weekdays: _____ Weekends: _____

Do you take naps during the day? ☐ No Naps Are the naps refreshing? ☐ Yes ☐ No

If YES: When? _____ How many? _____ How long? _____

Do you, or have you been told that you:	0 = Never, 1 = Occasionally, 2 = Often, 3 = Always			
Have trouble falling asleep at night?	☐ 0	☐ 1	☐ 2	☐ 3
Feel that you have to try hard to fall asleep?	☐ 0	☐ 1	☐ 2	☐ 3
Have trouble falling back asleep after you awaken?	☐ 0	☐ 1	☐ 2	☐ 3
Dread getting into bed for fear of "never falling asleep"?	☐ 0	☐ 1	☐ 2	☐ 3
Snore? ☐ None ☐ Mild ☐ Moderate ☐ Severe	☐ 0	☐ 1	☐ 2	☐ 3
Hold your breath while sleeping?	☐ 0	☐ 1	☐ 2	☐ 3
Wake up with headaches?	☐ 0	☐ 1	☐ 2	☐ 3
Feel refreshed in the morning upon awakening?	☐ 0	☐ 1	☐ 2	☐ 3
Experience crawling/aching feelings in your legs that make you want to move/walk?	☐ 0	☐ 1	☐ 2	☐ 3
Legs jerk before or during sleep?	☐ 0	☐ 1	☐ 2	☐ 3

Patient Name: _____

Patient Sleep History Questionnaire

Medical History

- ☐ High Blood Pressure
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Coronary Artery Disease
- ☐ Back/Neck Pain (chronic)
- ☐ ADD or ADHD
- ☐ Bipolar Disorder
- ☐ Lung Disease (COPD)
- ☐ Elevated Cholesterol
- ☐ Stroke
- ☐ GI Disease (ulcers, colitis, etc.)
- ☐ Teeth Grinding/Bruxism
- ☐ Nocturia/Frequent nighttime urination
- ☐ Heart Valve Problems
- ☐ Gastric Reflux
- ☐ Depression
- ☐ Cancer: _____
- ☐ Liver Disease/Hepatitis
- ☐ Seizures or Epilepsy
- ☐ Migraines or Frequent Headaches
- ☐ Parkinson's
- ☐ Dementia/Alzheimer's
- ☐ Fibromyalgia
- ☐ Congestive Heart Failure
- ☐ Neuropathy (nerve problems)
- ☐ Anxiety
- ☐ Substance Abuse: _____

Are you allergic to any medications/drugs? Yes: _____

List ALL medications/drugs you are taking or recently have taken within the past 6 months: ☐ *List Attached*

Prescription Medicines	Dosage	How Often	Reason

Over-the-Counter (OTC) Medicines	Dosage	How Often	Reason

Past Medical or Surgical history (include all hospitalizations within the past five years): ☐ *List Attached*

Problem	Date of Onset	Resolved/Current	Treatment

Patient Name: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice takes effect on 1/1/2005 and remains in effect until we replace it.

ABOUT US: In the Notice, we use terms like "we", "us" or "our" to refer to Apnix, its physicians, employees, staff and other personnel. All of the sites and locations of Apnix follow the terms of the Notice and may share health information with each other for treatment, payment, or health care operations purposes as described in this notice.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION: The Privacy of your medical information is important to us. We understand that your medial information is personal, and we are committed to protecting it. We create a record of the care and services you receive at Apnix. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY:

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION: The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at anytime by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your healthcare providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Notice of Privacy Practices

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, Or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs. Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement Official, reporting death, crimes on our premises, and crimes in emergencies.

DMEPOS SUPPLIER STANDARDS: May be found online here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/

4. YOUR INDIVIDUAL RIGHTS: You have a right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge a flat rate of $50.00, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at Apnix.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or it you think that we may have violated your privacy rights, please contact us at: Apnix, 4003-F Bellaire Blvd., Houston, Texas 77025, Telephone: 713-349-9767 or Toll-Free 866-442-7649. Contact ACHC at (855) 937-2242 or complete a Complaint Intake Form on the ACHC website. Notification of receipt of grievance will be within 5 business days and response given within 14 days. You may also submit a written complaint to the U.S. Department of Health and Human Services at 200 Independence Avenue. S.W., Washington, D.C. 20201. Telephone: 202-619-0257 or Toll Free: 1-877-696-6775. We will not retaliate in any way if you choose to file a complaint.