SEATTLE PAIN RELIEF

INTERVENTIONAL PAIN MEDICINE
35002 Pacific Highway South Suite A-105
Federal Way WA 98003
P: 253·944·1289 F: 253·944·1292

PATIENT INFORMATION

Date_____ Sex: □ M □ F

Patient_____

Address_____

City _____State_____Zip_____

Birth Date _____ Age: _____

Patient SSN_____

Occupation_____

Employer_____

Employed: □Full-Time □Part-Time □Not Working

If you are unemployed, is this due to your present pain condition: □ Yes or □ No

If you are currently unemployed, indicate how long you have been off of work:_____

PHONE NUMBERS

Home:_____Work: _____

Cell:_____Other:_____

Email:_____

EMERGENCY CONTACT:_____

Relationship:_____

Phone #:_____

Referring MD _____

Phone #_____

Facility:_____

Primary Care MD_____

Phone #_____

Facility: _____

Spouse's Name_____

Spouse's SSN:_____DOB:_____

Whom may we thank for referring you?

INSURANCE

Insured:_____

Relationship: _____

Insurance Co:_____

ID Number:_____

☐ Auto Insurance

Additional Insurance:_____

Subscribers Name:_____

Birth Date:_____**SS#:**_____

Relationship to Patient:_____

Insurance Co:_____

ID Number:_____

ACCIDENT INFORMATION

Is this condition due to an accident: ☐ YES ☐NO

☐ Worker's Compensation

☐ Personal Injury/Liability

☐ Auto Accident

To whom have you made a report of this accident:

☐ Employer

☐ Workers Compensation

☐ Other

Attorney Name & Phone Number if applicable:

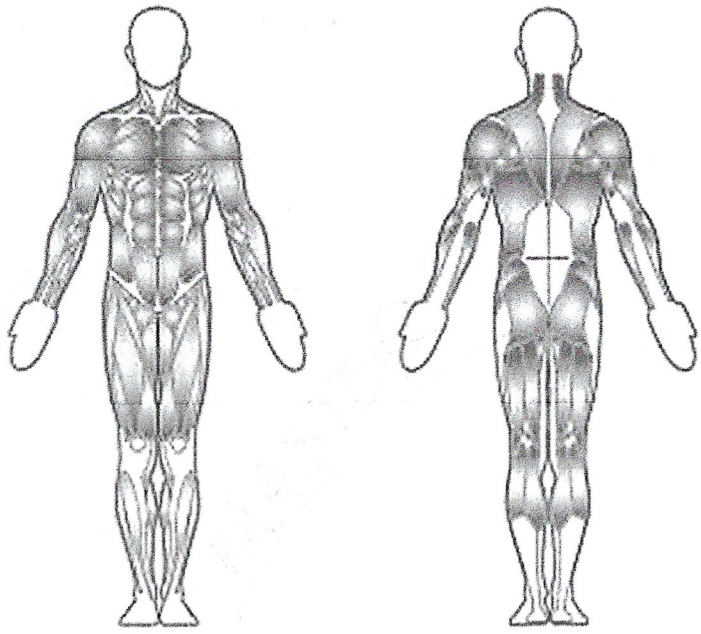
_____

_____

CHIEF COMPLAINTS OF PAIN

LOCATION OF PAIN/BODY SITE

PLEASE MARK THE LOCATIONS OF YOUR PAIN ON THE DIAGRAM



My pain is best described as:

□ Aching	□ Sharp	□ Penetrating
□ Throbbing	□ Tender	□ Nagging
□ Shooting	□ Burning	□ Numb
□ Stabbing	□ Exhausting	□ Miserable
□ Gnawing	□ Tiring	□ Unbearable
□ Intermittent	□ Continuous	

My pain is the result of:

□ Unknown	□ After lifting heavy objects	□ MVA
□ Shingles	□ Work related	□ Falling
□ Sports injury	□ Physical altercation	
□ Surgery _____	□ Disease _____	
□ Other _____		

My pain is present:

□ Continually	□ Constantly	□ Intermittently	□ On a daily basis	□ Only in the _____am _____pm
□ Only with walking		□ weekly	□ Only with activity such as _____	

INTENSITY OF PAIN

Circle the number that best describes your pain at its worst during the last month:

No Pain										Worst Pain Imaginable
0	1	2	3	4	5	6	7	8	9	10

Average _____ Best_____ Worst_____

HOW DO THE FOLLOWING AFFECT YOUR PAIN (PLEASE CHECK ONE FOR EACH ITEM)?

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING/SNEEZING			
PUSH/PULL			
BEND			

HEALTH HISTORY

DIAGNOSTIC STUDIES:

X-RAYS: □YES □ NO Date_____

*What Areas of the Spine*_____

MRI (Magnetic Resonance Imaging): □YES □ NO Date_____

*What Areas of the Spine*_____

PHYSICIAN INFORMATION

If Applicable:

Cardiologist Name: _____ Facility Name: _____ Phone Number: _____

Other:_____

PAIN TREATMENTS: Please check your response to the treatments you have tried.

TREATMENT	NEVER TRIED	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY				
TRACTION				
INJECTION				
TYPE:				
PHYSICAL THERAPY				
ACUPUNCTURE				
CHIROPRACTIC				
PSYCHOLOGICAL				

PAST MEDICAL HISTORY

MEDICAL HISTORY:

□ Heart Disease □ Stroke □ Cancer □ Arthritis □ Diabetes □ Hypertension
□ Asthma □ Thyroid □ Anxiety □ Depression □ Bleeding Disorders
□ Other _____

PAST SURGICAL HISTORY:

List all surgical procedures you have had (include pacemaker/defibrillator, joint replacement/fusion or vascular stints) and the date:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SOCIAL HISTORY:

Marital Status:

What is your current marital status? □ Single □ Married □ Divorced □ Widowed □ Separated

Has your marital status changed since your pain problem began? □ Yes □ No

Residence: □ House □ Apartment □ Condo □ Mobile Home

Number of people living with you: _____ Number of children living with you: _____

FAMILY HISTORY:

Has anyone in your family suffered from chronic pain? □ Yes □ No

If yes, what condition: _____

LEGAL MATTERS

Are you presently involved in a lawsuit? □ Yes □ No

If yes, please explain: _____

PAST MEDICAL HISTORY CONITNUED

EDUCATION:
What is the highest level of education you've finished? _____

EMPLOYMENT:
Are you currently working? □ Yes □ No □ Retired
Is this the same occupation you had before your pain started? □ Yes □ No
If not working, has the pain forced you to stop working? □ Yes □ No
If not working, what was your occupation before your pain problem? _____
Does your spouse work? □ Yes □ No Occupation: _____
Are you being treated under Workers Compensation? □ Yes □ No
Are you currently receiving disability benefits? □ Yes □ No

WORK HISTORY:
Occupation: _____ Years Worked: _____
Reason for Leave: _____

HABITS:
Do you smoke or use tobacco in any form? □ Yes □ No How many packs/day? _____ # years_____
Do you drink alcoholic beverages? □ Yes □ No How many drinks/day? _____
Do you use any recreational or street drugs? □ Yes □ No If yes, please list: _____
Do you drink caffeinated beverages? □ Yes □ No If yes, how much per day: _____

Which of the following drugs or substance, if any, have you used in the PAST? (Check all that apply)
Next to each drug or substance that you've checked, indicate if you used it occasionally "O" or "F", or continuously "C"

□ Alcohol ___ O ___ F ___ C □ Barbiturates ___ O ___ F ___ C □ Cocaine ___ O ___ F ___ C
□ Heroin ___ O ___ F ___ C □ Amphetamines ___ O ___ F ___ C □ Marijuana ___ O ___ F ___ C
□ Other _____ ___ O ___ F ___ C

Are you PRESENTLY using any of the drugs or substance below? (Check all that apply)
Next to each drug or substance that you've checked, indicate if you used it occasionally "O" or "F", or continuously "C"

□ Alcohol ___ O ___ F ___ C □ Barbiturates ___ O ___ F ___ C □ Cocaine ___ O ___ F ___ C
□ Heroin ___ O ___ F ___ C □ Amphetamines ___ O ___ F ___ C □ Marijuana ___ O ___ F ___ C
□ Other _____ ___ O ___ F ___ C

CURRENT MEDICATIONS:
List all medications you are currently taking:

1. _____ Dose: _____ Frequency: _____
2. _____ Dose: _____ Frequency: _____
3. _____ Dose: _____ Frequency: _____
4. _____ Dose: _____ Frequency: _____
5. _____ Dose: _____ Frequency: _____
6. _____ Dose: _____ Frequency: _____
7. _____ Dose: _____ Frequency: _____
8. _____ Dose: _____ Frequency: _____

ALLERGIES:
Please indicate the names of any medications to which you are allergic: _____

_____

What type of reaction did you have? _____

I am allergic to contrast dye used for X-ray: ☐ Yes ☐ No Do you take Aspirin, Plavix or Coumadin? ☐ Yes ☐ No

Are you afraid of needles/sharp objects? ☐ Yes ☐ No

Intolerances: (include side effects form pervious medications, i.e.; gastritis, nauseas, constipation, etc.)

_____

_____

_____

What are your treatment goals at Seattle Pain Relief?

_____

_____

_____

_____

HIPAA PRIVACY PRACTICES

I, _____ have received a copy of the HIPAA Notice of Privacy Practices.

I have read and understand my rights as afforded to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that I may ask questions of the office.

Name: _____

Signature: _____ Date: _____

SEATTLE PAIN RELIEF
INTERVENTIONAL PAIN MEDICINE

Patient Name: _____

Patient Date of Birth: _____

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I HEREBY AUTHORIZE:

_____ _____

_____ _____

_____ _____

TO RELEASE THE FOLLOWING INFORMATION:

☐ Last 6 months of chart notes
☐ Imaging Reports (no cd's please)
☐ Specific Information: _____

_____

DESIGNATED INFORMATION IS TO BE:

Fax: (253) 397-3207

Email: medicalrecords@seattlepainrelief.com

INFORMATION RELEASED TO:

Federal Way Ambulatory Surgical Facility – 35002 Pacific Highway South Suite A105 – Federal Way, WA 98003

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health conditions.

MY RIGHTS:

Seattle Pain Relief is hereby released from all legal responsibility or liability for the release of information designated above. I understand that I have the right to withdraw this authorization at any time and that such revocation must be done in writing. I also understand that this authorization, without prior, revocation, will expire 90 days from the date of signature.

INDIVIDUAL OR REPRESENTATIVE SIGNATURE	
I, _____, have had full opportunity to read and consider the contents of this HIPAA authorization, and I understand that, by signing this form, I confirm my authorization of the use and/or disclosure of my PHI, as set forth in this form.	
Signature:	Date:
If this revocation is signed by a personal representative on behalf of the individual, complete the following:	
Personal Representative's Name:	
Signature:	Date:
Relationship to Individual:	

Patient Name: _____ Date: _____

PATIENT PORTION: Mark each item below that applies.

		FOR OFFICE STAFF ONLY! Female	Male
1) Family History Of Substance Abuse:			
a. Alcohol	[__]	1	3
b. Illegal Drugs	[__]	2	3
c. Prescription Drugs	[__]	4	4
2) Personal History Of Substance Abuse:			
a. Alcohol	[__]	3	3
b. Illegal Drugs			
c. Prescription Drugs			
3) Age (Mark Box If Between the ages of 16-45)	[__]	1	1
4) History Of Preadolescent Sexual Abuse	[__]	3	0
5) Psychological Disease (Any Of the Below):	[__]	2	2
a. Attention Deficit Disorder			
b. Obsessive Compulsive Disorder			
c. Bipolar			
d. Schizophrenia			
6) Personal History Of Depression	[__]	1	1
		Total:	
		_____	_____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request patient records, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's direct consent. If you wish to have your medical information, any procedure information and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize Seattle Pain Relief to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages

(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

Patient Name (PLEASE PRINT) _____

Patient Signature: _____

Date _____ Authorization Valid Through: _____

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INTERVENTIONAL PAIN MEDICINE
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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. NOTICE OF PRIVACY PRACTICES PURSUANT TO 45 C.F.R. S 164.520

1. Our Duties

We are required by law to maintain the privacy of your Protected Health Information ("Protected Health Information"). We must also provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. We are required to abide by the terms of our Notice of Privacy Practices currently in effect. However, we reserve the right to change our privacy practices in regard to Protected Health Information and make new privacy policies effective for all Protected Health Information that we maintain. We will provide you with a copy of any current privacy policy upon your written request, addressed to our Privacy Officer, at our current address.

2. Your Complaints

You may complain to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by sending a certified letter addressed to "Privacy Officer" at our current address, stating what Protected Health Information you believe has been used or disclosed improperly. You will not be retaliated against for making a complaint. For further information you may contact our Privacy Officer, at telephone number 253-944-1289.

3. Description and Examples of Uses and Disclosures of Protected Health Information

Here are some examples of how we may use or disclose your Protected Health Information. In connection with treatment, we will, for example, allow a physician associated with us to use your medical history, symptoms, injuries or diseases to treat your current condition. In connection with payment, we will, for example, send your Protected Health Information to your insurer or to a federal program, such as Medicare, that pays for your treatment. This allows us to obtain payment for the services we rendered on your behalf. In connection with health care operations, we will, for example, allow our auditors, consultants, or attorneys' access to your Protected Health Information to determine if we billed you accurately for the services we provided to you.

4. Uses and Disclosures Which Require Your Written Authorization

Uses and disclosures other than those involving treatment, payment, and health care operations, as well as those described in the following sections of this Notice, will only be made by obtaining a written authorization from you. You may revoke this authorization in writing at any time, except to the extent that we have taken action in reliance upon your authorization.

5. Uses and Disclosures Not Requiring Your Written Authorization

The privacy regulations give us the right to use and disclose your Protected Health Information if: (I) you are an inmate in a correctional institution; (ii) we have a direct or indirect treatment relationship with you, (iii) we are so required or authorized by law. The purposes for which we might use your Protected Health

Information would be to carry out treatment, payment, and health care operations similar to those described in Paragraph 1.

6. Uses of Protected Health Information to Contact You

We may use your Protected Health Information to contact you regarding appointment reminders or to contact you with information about treatment alternatives or other health-related benefits and services that, in our opinion, may be of interest to you. We may use your Protected Health Information to contact you in an effort to raise funds for our operations.

7. Disclosures of Protected Health Information for Billing Purposes

We may disclose your billing information to any person that calls our billing staff or agents with billing questions after we verify the identity of the person by requesting information such as your social security number or health plan number.

8. Disclosures for Directory and Notification Purposes

If you are incapacitated or not present at the time, we may disclose your Protected Health Information (a) for use in a facility directory, (b) to notify family or other appropriate persons of your location or condition, and (c) to inform family, friends or caregivers of information relevant to their involvement in your care or payment for your treatment. If you are present and not incapacitated, we will make the above disclosures, as well as disclose any other information to anyone you have identified, only upon your signed consent, your verbal agreement, or the reasonable belief that you would not object to such disclosure(s).

9. Individual Rights (i)

You may request us to restrict the uses and disclosures of your Protected Health Information, but we do not have to agree to your request. (ii) You have the right to request that we communicate with you regarding your Protected Health Information in a confidential manner or pursuant to an alternative means, such as by a sealed envelope rather than a postcard, or by communicating to a specific phone number, or by sending mail to a specific address. We are required to accommodate all reasonable requests in this regard. (iii) You have the right to request that you be allowed to inspect and copy your Protected Health Information as long as it is kept as a designated record set, and as long as you pay in advance for the administrative time and costs to make arrangements to have the records inspected and copied. Certain records are exempt from inspection and cannot be inspected or copied, so each request will be reviewed in accordance with the standards published in 45 C.F.R. S 164.524. (iv) You have the right to amend your Protected Health Information for as long as the Protected Health Information is maintained in the designated record set. We may deny your request for an amendment if the Protected Health Information was not created by us, or is not part of the designated record set, or would not be available for inspection as described under section 45 C.F.R. S 164.524, or if the Protected Health Information is already accurate and complete without regard to the amendment. (v) You have the right to request, and thereafter receive, an accounting of the disclosures of your Protected Health Information for six years before the date on which you request the accounting. An exception to this accounting are those disclosures not allowed by law pursuant to section 164.528. Each request for an accounting will be reviewed pursuant to the rules of section 164.528. (vi) You also have a right to receive a copy of this Notice upon request.

10. Effective Date

The effective date of this Notice is January 01, 2015.

Signature of Patient or Authorized Representative:

_____

Print Name _____

Relationship: _____ Date: _____

SEATTLE PAIN RELIEF
INTERVENTIONAL PAIN MEDICINE
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FINANCIAL POLICY, CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION

Thank you for choosing Seattle Pain Relief as you partner in pain management.

PLEASE READ CAREFULLY

- Official Identification and Insurance information (primary and secondary) must be presented/updated at the time of making your appointment not at the time of service. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals you will not be seen and your appointment will be rescheduled.

- **Payment in full for non-insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.**

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- Seattle Pain Relief is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates. Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- For services that are not covered by insurance or are subject to deductible/co - insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

FINANCIAL POLICY, CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION (CONT'D)

- Insured individuals electing to be self-pay. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. Seattle Pain Relief will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

- If you do not have insurance coverage for the service, are self-pay, or have insurance that Seattle Pain Relief does not participate in or accept, payment is expected at the time of service. Seattle Pain Relief has established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service. No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law. If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled.

- Out of Network Insurance – Some insurance plans require you to pay different out-of- pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and copayments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self-pay.

- Insurance information provided after the services have been provided will be billed or not billed at the discretion of Seattle Pain Relief. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If Seattle Pain Relief agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

- The patient is responsible for any balances not paid by the insurance carrier 30 days after the claim has processed or 4 weeks after receiving a statement from Seattle Pain Relief. **Balances not paid within 30 days will be forwarded to a collection agency and will result in a dismissal from care.** **No payment plans are authorized.**

- Balances owing over 60 days will accrue a 3% interest.

- In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00.

    - Should collection proceedings or other legal action become necessary to collect an overdue account, patient understands that the provider has the right to disclose to an outside collection agency all relevant personal and account information necessary to collection payment for services rendered. The patient understands that they are responsible for all costs of collection including collection/attorney fees.

- In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Please note that our office charges $50.00 for missed appointments and $200.00 for missed procedures. Please contact our office 48 hours in advance to reschedule your appointment in order to avoid these fees.

FINANCIAL POLICY, CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION (CONT'D)

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 48 hours) cancelling of appointment or not showing up for their appointments will be subject to reviewed for dismissal from our practice.

- Patients with 2 consecutive missed appointments, 3 "No Shows" or 4 cancellations may be discharged from care.

- **Urine Analysis:** All samples are sent out to an **outside lab** for testing/ confirmation and billing. All billing questions for lab tests must be forwarded to Quest Diagnostics. Seattle Pain Relief is not responsible for any billing issues associated with urine, blood, or saliva tests.

    - I understand that I will be financially responsible for the charges for any urine, blood, or saliva test. If you have insurance coverage it will be billed but you will be responsible for all patient liability.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Seattle Pain Relief to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Seattle Pain Relief. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to Seattle Pain Relief. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give Seattle Pain Relief permission to appeal any denials by my insurance for services rendered on my behalf and/or to initiate a complaint to the insurance commissioner for any reason on my behalf.

I will assist Seattle Pain Relief with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read Seattle Pain Relief's Financial Policy, Consent for Treatment, Release of Medical Information, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

Patient / Responsible Party Name

Patient / Responsible Party Signature Date

SEATTLE PAIN RELIEF

INTERVENTIONAL PAIN MEDICINE

MISSED/CANCELED APPOINTMENT POLICY

We ask that you inform us at least **24 hours** in advance if you need to cancel or reschedule **ANY** appointments. If you cancel within 24 hours or you are a no call no show, you will be subject to the late cancellation/no show fee(s). The fees are as follows:

Office Exam or Medication Follow Up: **$50**

New or Previous Patient Consults: **$100**

CRV, CCP, or Treatment Plan: **$100**

Procedure: **$200**

Should the patient fail a second appointment, we will send you a letter notifying you that a third appointment may result in dismissal from the practice. If the patient violates the cancellation policy three times within one year, they may be discharged from the facility. A letter will be sent informing the patient that we will provide 30 days emergency care only along with resources. During that time, we recommend the patient find another physician for pain management, we will then transfer the medical records upon receipt of a signed request with the new physician's name and address.Thank you for your cooperation and understanding.

Please sign below confirming your understanding of the missed/canceled appointment policy.

_____

Patient Signature Date

_____

Witness Date

Please provide Credit Card to be charged for missed/canceled appointment:

CC#:_____ EXP _____/_____ CVV_____

Authorized Signature:

_____

By signing above, you authorize Seattle Pain Relief to charge your card the fee that applies to the appointment(s) you have late canceled or missed.