

PART ONE

PATIENT QUESTIONNAIRE / INTAKE

Dear Patient: You must fax (1-888-688-4167) or email this information to our office at least 2 days before your appointment. If it is not recieved, you will be re-scheduled. Please call our office as soon as possible to cancel or change your appointment. Our email address is: nopain@soundinterventionalpain.com

Your Name _____

Day Phone # _____ Evening Phone # _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____

Primary Physicians's Name, Address, and Phone _____

Referring Physician's Name, Address, and Phone _____

Preferred Pharmacy _____ Phone # _____

QUESTIONS ABOUT YOUR CURRENT PROBLEM:

1. When did your pain problem first occur? _____

2. How did it happen? ☐ Accident at work ☐ Accident at home ☐ Following surgery
Please check (✓) one: ☐ Car accident ☐ Other accident _____
☐ Following illness ☐ Pain just began - cannot relate it to anything

3. Have you ever had this pain before? If yes, explain. _____

4. Place an X on each line between 0 and 10 to indicate your level of pain last week:

Worst this week _____
(no pain) 0 10 (worst possible pain)

Best this week _____
(no pain) 0 10 (worst possible pain)

Average this week _____
(no pain) 0 10 (worst possible pain)

5. What makes your pain worse? _____

6. What makes your pain better? _____

7. ☒ Yes ☐ No Do you think your pain is caused by something that is different or more serious than what your doctor has told you?

8. What do you think is the cause of your pain? _____

Patient Name:

DOB:

MRN:

Clinic Location:

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9. Where is your pain located?

Mark the areas on the body where you feel the described sensations using the following marking:

(Note: If you are filling out this form online, you cannot draw on this form. Please verbally describe WHERE the pain is on this line _____)

Burning: ///

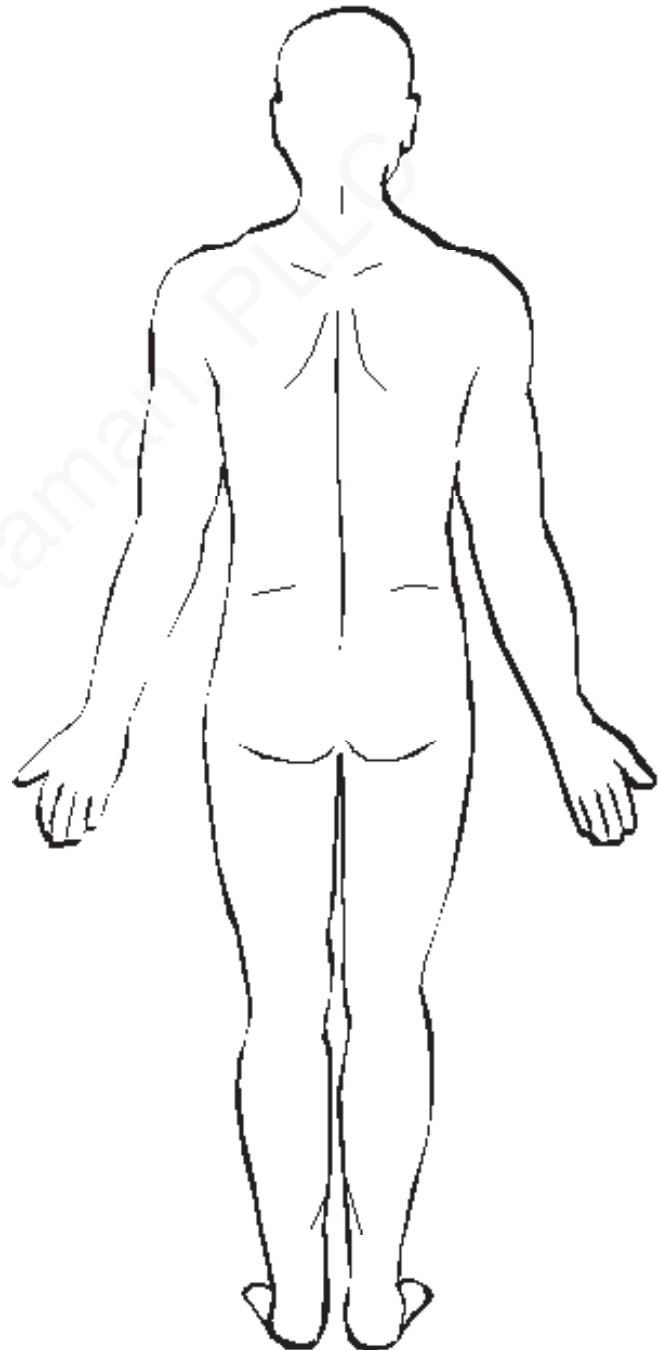
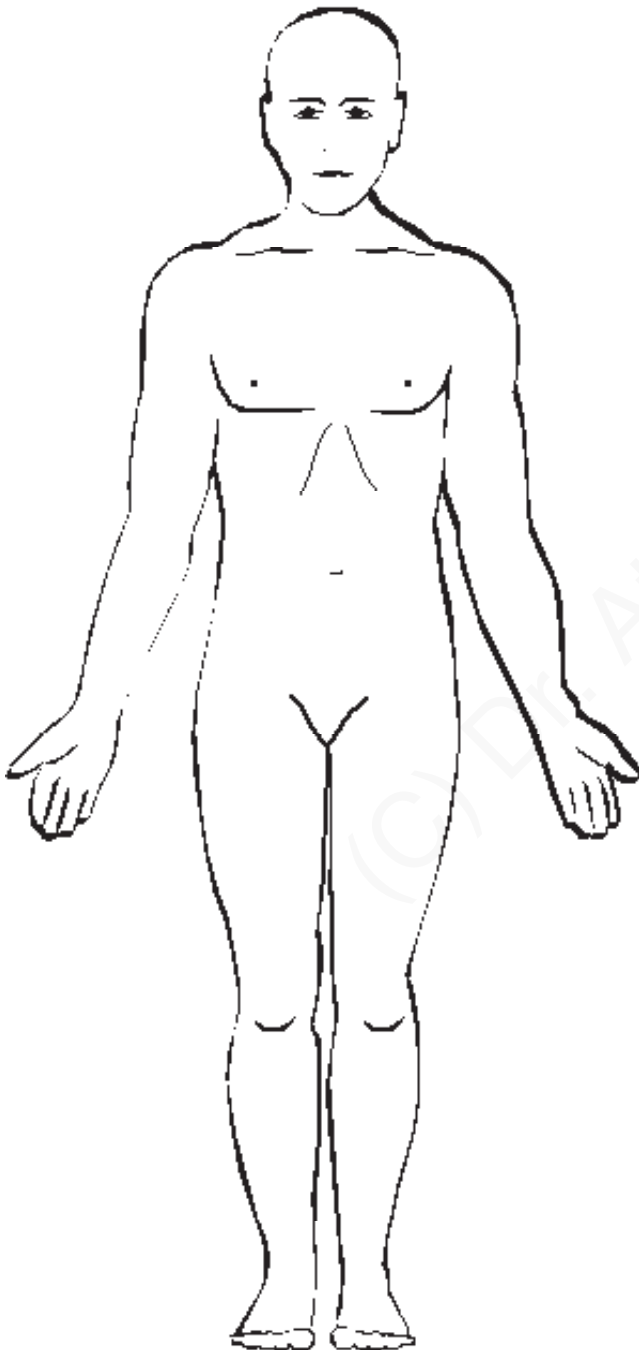
Achiness: ||||

Numbness: - - - -

Pins/needles: O O O O

Pain: X X X X

Stabbing: ▽ ▽ ▽ ▽



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DIAGNOSTIC TESTS DONE FOR YOUR PROBLEM:

<u>Test</u>	<u>When Done?</u>	<u>What Hospital/Clinic?</u>	<u>Findings</u>
X-Ray (what body part?)			
CT (CAT Scan)			
MRI			
Bone Scan			
EMG			
Myelogram			
Other tests:			

MEDICATIONS:

Please list all the medications you **currently** take for **any reason** (including non-prescription drugs):

[illegible]

Please list all known drug allergies: _____

PAST MEDICAL HISTORY:

[illegible]

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TREATMENT HISTORY

Please check (✓) all treatments you have received for this problem:

- | | | |
|---|--|--------------------------------------|
| ☐ Medication | ☐ Physical Therapy | ☐ Surgery |
| ☐ Injections or nerve blocks | ☐ Manipulation or other chiropractic treatments | ☐ TENS |
| ☐ Occupational therapy | ☐ Psychological/psychiatric counseling | ☐ Acupuncture |
| ☐ Biofeedback | ☐ Pain program | ☐ Massage |

☐ Homeopathic or other alternative medicine (please list): _____

Please list the names, addresses, and phone numbers of pain specialists you have seen:

Please list the exact types of pain injection therapy you have received:

<i>Type of Pain Injection Therapy:</i>	<i>When</i>	<i>Performing Physician</i>

FUNCTIONAL STATUS:

☐ Yes ☐ No Do you have trouble getting to sleep because of your pain?

☐ Yes ☐ No Can you sleep through the night?

If no, I sleep a total of _____ hrs/night and wake _____ times/night due to pain.

☐ Yes ☐ No Do you have difficulty with prolonged sitting?

If yes, I can sit _____ minutes before I need to get up and move around due to pain.

☐ Yes ☐ No Do you have difficulty with prolonged walking?

If yes, I can walk continuously for _____ minutes before I need to sit or rest due to pain.

☐ Yes ☐ No Do you have difficulty with prolonged standing?

If yes, I can stand continuously for _____ before I need to sit or lie down due to pain.

☐ Yes ☐ No Do you exercise? If yes, I exercise: ☐ 3 or more times per week ☐ 1 time per week or more
☐ Less than 1 time per week ☐ Never

What kind of exercises do you do? _____

☐ Yes ☐ No Do you avoid doing certain daily activities due to a fear of flaring up your pain condition?

Instructions: Please indicate how much you agree with each of the following statements by using the following scale:

	very untrue				very true
1. Exercise and movement are good for my pain problem	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. If I exercise, I could make my pain problem much worse	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. If I do not exercise regularly, my pain problem will continue to get worse	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Exercise can decrease the amount of pain I experience	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

It is imperative that you submit the required health information as soon as possible for proper medical treatment.

Patient Name _____ DOB _____

I voluntarily authorize and direct my health care provider _____

to use or disclose my health information during the term of this authorization to the recipient listed below:

Dr. Attaman, PLLC
(866) 830-8245 fax
doctorattaman@gmail.com

Mailing Address:
4701 SW Admiral Way #217
Seattle, WA 98116

PURPOSE: I understand that the specific purpose of this Authorization is for the continuity of medical treatment for pain related conditions. **NOTE:** By law we cannot require that you sign this authorization. However we must disclose that refusal to release these records will hamper and delay proper and quality treatment of your pain condition.

INFORMATION TO BE DISCLOSED: This authorization permits the above provider to disclose the following medical records:

- ☐ Images (MRI, CT, US, etc.) related to pain diagnoses and/or specific anatomical region _____
- ☐ Imaging reports related to pain diagnoses and/or specific anatomical region _____
- ☐ Clinic notes related to a pain diagnoses, including _____
- ☐ Procedure notes related to a pain diagnoses, including _____
- ☐ Lab reports related to a pain diagnoses, including _____
- ☐ Other _____

TERM: This authorization will remain in effect:

- ☐ From the date of this Authorization until the date of _____
- ☐ Until the Provider fulfills this request.
- ☐ At expiration of one year from the date this disclosure is signed.

REDISCLOSURE: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party (particularly if such disclosure is required by law).

REFUSAL TO SIGN/RIGHT TO REVOKE: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement or continuation of my treatment by my health care provider.

REVOCAION: I understand that this authorization will remain in effect until it expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my notice, except that the revocation will not have any effect on action taken by my health care provider in reliance on this authorization before it received my notice of revocation.

QUESTIONS: I may contact the Privacy Officer for answers to my questions about the privacy of my health information at: Dr. Attaman, PLLC, 4701 SW Admiral Way #217, Seattle, WA 98116. I may also use this address to submit a revocation of this authorization or to inform the office of any unauthorized release of my health information.

Signature

Print Name

Date

If Individual is unable to sign this Authorization, please complete the information below:

Signature of Guardian/Representative

Print Guardian/Representative Name

Date

The HIPAA Privacy Rule (45 CFR §164.524(d)(3)) requires that programs respond to a patient's request for access to records within 30 days after receipt of the request. Noncompliance will be reported to the Office of Inspector General.

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HEALTH HISTORY:

- ☐ Yes ☐ No Tumors or cancer? If yes, what type?

- ☐ Yes ☐ No Kidney stones?
- ☐ Yes ☐ No Urinary tract infection in the last year?
- ☐ Yes ☐ No Tooth abscess or any other infection in the last year?
- ☐ Yes ☐ No Epilepsy?
- ☐ Yes ☐ No Treated for headaches?
- ☐ Yes ☐ No Head injury with loss of consciousness?
- ☐ Yes ☐ No Hypothyroid or thyroid problem?
- ☐ Yes ☐ No Treated for a psychiatric disorder?
- ☐ Yes ☐ No Circulatory problems?
- ☐ Yes ☐ No Do you have a history of stroke?
- ☐ Yes ☐ No Heart problem? If yes, describe:

- ☐ Yes ☐ No Aortic aneurysm?
- ☐ Yes ☐ No Currently do you have high blood pressure?
- ☐ Yes ☐ No Taking heart medications?
- ☐ Yes ☐ No Currently, do you have a cholesterol level above 200? If yes, what is it?

- ☐ Yes ☐ No Are you diabetic? If yes, are you insulin dependent? ☐ Yes ☐ No
- ☐ Yes ☐ No History of respiratory disorders (asthma, emphysema)?
- ☐ Yes ☐ No Intestinal disorder?
- ☐ Yes ☐ No Gastrointestinal reflux (GERD)?
- ☐ Yes ☐ No AIDS or related diseases (HIV positive)?
- ☐ Yes ☐ No Hepatitis?
- ☐ Yes ☐ No Allergies? If so, what:

- ☐ Yes ☐ No Any disease of the nerves or muscles? If so, what:

- ☐ Yes ☐ No Arthritis? What type:

- ☐ Yes ☐ No History of serious injury?
- ☐ Yes ☐ No Do you have a fever by thermometer?
- ☐ Yes ☐ No Have you noticed weakness in your arms or legs? If yes, where?

When does it occur?

- ☐ Yes ☐ No Have you lost weight lately without dieting?
- ☐ Yes ☐ No Have you gained weight lately? If yes, how much?

- ☐ Yes ☐ No Have you lost control of your bowels and/or bladder?
- ☐ Yes ☐ No Any blood in your bowel movements?
- ☐ Yes ☐ No Any blood in your urine?
- ☐ Yes ☐ No (Men only) Have you had difficulty with erections?
- ☐ Yes ☐ No Any abnormal discharge or soiling of your underwear?
- ☐ Yes ☐ No Chest pain when you work hard?
- ☐ Yes ☐ No Do you get short of breath easily?
- ☐ Yes ☐ No Skin rash?
- ☐ Yes ☐ No Frequent headaches?
- ☐ Yes ☐ No Visual changes?
- ☐ Yes ☐ No Excessively dry eyes?
- ☐ Yes ☐ No Difficulty with loud noises?
- ☐ Yes ☐ No Severe pain or tenderness on the side of your head?
- ☐ Yes ☐ No Ear pain or difficulty hearing?
- ☐ Yes ☐ No Frequent sores in your mouth?
- ☐ Yes ☐ No Difficulty chewing and swallowing?
- ☐ Yes ☐ No Pain in your jaw?
- ☐ Yes ☐ No Do you experience increased pain with coughing, sneezing or straining?
- ☐ Yes ☐ No Any pain in the joints of your hands, arms or legs?
- ☐ Yes ☐ No Heartburn or pain when eating spicy foods?
- ☐ Yes ☐ No Do you feel sad or anxious most of the time?
- ☐ Yes ☐ No Do you have problems with anxiety or panic attacks?
- ☐ Yes ☐ No If your pain was caused by an accident, do you have nightmares or flashbacks of the accident, or avoid things that remind you of the accident?
- ☐ Yes ☐ No Do you notice that you have a low level of energy, or get tired easily?
- ☐ Yes ☐ No Have you lost interest in things that you used to enjoy doing?
- ☐ Yes ☐ No Do you find that you don't want to be bothered by being around other people?
- ☐ Yes ☐ No Do you frequently wish you were dead or think about ways to end your life?
- ☐ Yes ☐ No Have you ever been hospitalized? If yes, please list:

- ☐ Yes ☐ No Do you have any other health problems not listed above?
If yes, please explain:

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FAMILY HISTORY: Has any family member had any of the following? Please check (✓) each that apply:

- ☐ Yes ☐ No Any blood relatives who have had a heart attack before age 55?
☐ Yes ☐ No Disabling back pain
☐ Yes ☐ No Disability from work for other reasons
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Muscle or nerve disease. If so, what _____
☐ Yes ☐ No Any other disease which might affect **your** treatment?
Please list: _____

SOCIAL HISTORY: Please check (✓) each that apply:

- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Who do you live with? ☐ Alone ☐ Children (ages _____) ☐ Spouse
☐ Parents ☐ Significant Other ☐ Friends or Relatives ☐ Other _____
How much alcohol do you usually drink? ☐ None ☐ 1-5 drinks per week
(1 drink = 1 can of beer, 1 glass of wine or 1 shot of liquor) ☐ 6-12 drinks per week ☐ More than 12 drinks per week
☐ Yes ☐ No Have you ever been treated for drug or alcohol abuse? When? _____
☐ Yes ☐ No Have you ever used illegal street drugs? Which? _____
☐ Yes ☐ No Have you been a cigarette smoker in the last 5 years?
☐ Yes ☐ No Currently, do you smoke? If yes, how much per day _____
☐ Yes ☐ No Has a physician prescribed medical marijuana to you? If yes, date last used _____
Number of years of schooling completed (i.e., 11th grade, 4 years of college, etc.)? _____
Please check (✓) if you have: ☐ GED ☐ Technical School Degree/Certificate
Aside from your current problem, what are the most stressful things in your life? _____

WORK STATUS:

- ☐ Yes ☐ No Do you believe this problem is caused by your work?
☐ Yes ☐ No Are you out of work because of this problem? If yes, since what date? _____
☐ Yes ☐ No If working, are you on physician ordered restrictions because of this problem?
If yes, please list restrictions: _____
Please list physician ordering restrictions: _____
Expiration date of restrictions: _____
☐ Yes ☐ No Have you ever lost work because of any injuries in the past?

Check (✓) all that apply:

- ☐ Job being held ☐ Retired ☐ Fired ☐ Student
☐ Working-Part Time ☐ Medical leave ☐ Self employed ☐ Other: _____
☐ Working-Full time ☐ Homemaker ☐ Not working - why? _____

Job title (current): _____

Employer / Company Name: _____ Address: _____

Supervisor's name: _____ Supervisor's phone: _____

Length of employment: Years: _____ Months: _____

Do you (did you) enjoy your work (check on scale where appropriate)?

☐ 0 NOT AT ALL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 VERY MUCH ☐ 6

In general, before your pain began, did your employer treat you fairly?

☐ 0 NOT AT ALL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 VERY FAIRLY ☐ 6

After your pain began, was your employer helpful and understanding of your pain problem?

☐ 0 NOT AT ALL ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 VERY HELPFUL & ☐ 6 UNDERSTANDING

Please select the category that best describes your work situation prior to your pain problem:

- ☐ **Sedentary:** Occasional 10 lb. lift; 10 lb. maximum
☐ **Light:** Frequent 10 lb. lift, 20 lb. maximum
☐ **Medium:** Less than 50 lb. frequently; 50 lb. maximum
☐ **Heavy:** Frequent 50 lb. lift; 100 lb. maximum
☐ **Very Heavy:** Frequent 50 lb. lift; greater than 100 lb. maximum

Key: Rarely = <10% of the time
Occasionally = 11-33% of the time
Frequently = 34-67% of the time
Continuously = 68-100% of the time

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FINANCIAL/LEGAL:

- ☐ Yes ☐ No Are you currently receiving compensation for your pain problem?
If yes, please check (✓) all sources that apply:
☐ Worker's Comp. ☐ No-fault Auto Insurance
☐ Social Security Disability ☐ Long Term Medical Disability
☐ Supplemental Security Income ☐ Sick Leave Disability Benefits
☐ Short Term Medical Disability
- ☐ Yes ☐ No Do you have a case manager?
If yes, circle appropriate category: ☐ Auto ☐ Worker's Comp. ☐ Other
Case Manager name: _____
Company _____ Phone (_____) _____ - _____
- ☐ Yes ☐ No Are you involved in any legal action (e.g. a court case) related to your pain?
If yes, please check (✓) what type of legal action you are in:
☐ Suit for Worker's Comp ☐ Suit for No-Fault Auto Insurance ☐ Suit for Social Security Disability Income
☐ Suit to increase your current compensation benefits
☐ Suit against a third party (employer, driver of another automobile, a doctor, etc.)
- ☐ Yes ☐ No Are there any other insurance or lien holders (mortgage, credit card, etc.) who require documentation that you are disabled?

The questions in the next section ask a number of the same things. They are arranged in a standardized fashion. Please answer each to the best of your ability. Thank you.

We would like to know how much your pain is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of the pain in your life, not just when the pain is at its worst.

Please check (✓) the number that describes the level of disability you usually experience. A score of **0** means that you can do these things with no problem or pain, and a score of **10** means you cannot do these normal activities because of your pain.

Family/Home Responsibilities: This category refers to activities related to home or family. It includes chores and duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Recreation: This category includes hobbies, sports and other similar leisure time activities.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Social Activity: This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes non-playing jobs as well, such as that of a housewife or volunteer worker.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Self Care: Includes activities which involve independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

Life-Support Activity: This category refers to basic life-supporting behaviors such as eating, sleeping and breathing.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
NO DISABILITY									TOTAL DISABILITY	

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Please place a check (✓) in the column that best describes your ability to perform the following tasks:

Key: 1 = No difficulty 2 = Mild difficulty 3 = Moderate difficulty 4 = Unable to do N/A = Not applicable

Activity	1	2	3	4	N/A
Shoe/sock on and off	☐	☐	☐	☐	☐
In/out of car	☐	☐	☐	☐	☐
Ride/drive long time	☐	☐	☐	☐	☐
Vacuuming	☐	☐	☐	☐	☐
Washing dishes	☐	☐	☐	☐	☐

Activity	1	2	3	4	N/A
Child in/out of car	☐	☐	☐	☐	☐
Grocery shopping	☐	☐	☐	☐	☐
Bathe/diaper child	☐	☐	☐	☐	☐
Lifting tasks	☐	☐	☐	☐	☐
Reach high or low	☐	☐	☐	☐	☐

Below are 20 different groups of words. Some of the words probably describe your current pain. Please check (✓) **ONLY** those words that you believe would **BEST** describe your current pain. **NEVER** check more than **ONE** word per group. If a group has no word to describe your pain, then **DO NOT** check any word in that group. **REMEMBER:** check only one word per group, and do not check a word in a group if no words in that group describe your pain.

1. (S) ☐ flickering ☐ throbbing ☐ quivering ☐ beating ☐ pulsing ☐ pounding	2. (S) ☐ jumping ☐ shooting ☐ flashing	3. (S) ☐ pricking ☐ boring ☐ drilling ☐ stabbing ☐ lancing	4. (S) ☐ sharp ☐ cutting ☐ lacerating	5. (S) ☐ pinching ☐ cramping ☐ pressing ☐ crushing ☐ gnawing
6. (S) ☐ tugging ☐ wrenching ☐ pulling	7. (S) ☐ hot ☐ scalding ☐ burning ☐ scarring	8. (S) ☐ tingling ☐ itching ☐ smarting ☐ stinging	9. (S) ☐ dull ☐ aching ☐ sore ☐ heavy ☐ hurting	10. (S) ☐ tender ☐ rasping ☐ taut ☐ splitting
11. (A) ☐ tiring ☐ exhausting	12. (A) ☐ sickening ☐ suffocating	13. (A) ☐ fearful ☐ frightful ☐ terrifying	14. (A) ☐ punishing ☐ vicious ☐ grueling ☐ killing ☐ cruel	15. (A) ☐ wretched ☐ blinding
16. (E) ☐ annoying ☐ intense ☐ troublesome ☐ unbearable ☐ miserable	17. (M) ☐ spreading ☐ piercing ☐ radiating ☐ penetrating	18. (M) ☐ tight ☐ numb ☐ squeezing	19. (M) ☐ cool ☐ cold	20. (M) ☐ nagging ☐ agonizing ☐ nauseating ☐ dreadful

Place a check mark (✓) in one box in each group below, to indicate which statements best describe your health.

Mobility:

- ☐ I have no problems walking about
☐ I am confined to bed

☐ I have some problems walking about

Self-Care:

- ☐ I have no problems with self-care
☐ I am unable to wash or dress myself

☐ I have some problems washing or dressing myself

Usual Activities (e.g., work, study, housework, family or leisure activities):

- ☐
- I have no problems with performing my usual activities
-
- ☐
- I have some problems with performing my usual activities
-
- ☐
- I am unable to perform my usual activities

Pain/Discomfort:

- ☐ I have no pain or discomfort
☐ I have extreme pain or discomfort

☐ I have moderate pain or discomfort

Anxiety/Depression:

- ☐ I am not anxious or depressed
☐ I am extremely anxious or depressed

☐ I am moderately anxious or depressed

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For each question below, please indicate how much you engage in that activity or thought when you feel pain. **A0** indicates you never do that when you are experiencing pain, a **3** indicates you sometimes do that when you are experiencing pain, and a **6** indicates you always do that when you are experiencing pain. Remember you can use any point along the scale.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
Never do that			Sometimes do that			Always do that

_____	1. It's terrible and I feel it's never going to get any better
_____	2. It's awful and I feel it overwhelms me
_____	3. I feel my life isn't worth living
_____	4. I worry all the time about when it will end
_____	5. I feel I can't stand it anymore
_____	6. I feel like it can't go on

Based on all the things you do to cope, or deal with your pain, how much control do you feel you have over it on an average day? Please check (✓) the appropriate number along each scale. Remember, you can check any number along the scale.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
No control			Some control			Complete control

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more. This questionnaire is designed to help your doctor to know how you feel. Read each item and check (✓) the box next to the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

1. I feel tense or wound up:
☐ Most of the time ☐ A lot of the time ☐ Time to time ☐ Not at all
2. I still enjoy the things I used to enjoy:
☐ Definitely as much ☐ Not quite so much ☐ Only a little ☐ Hardly at all
3. I get a sort of frightened feeling as if something awful is about to happen:
☐ Very definitely and quite badly ☐ Yes, but not too badly ☐ A little, but it doesn't worry me ☐ Not at all
4. I can laugh and see the funny side of things:
☐ As much as I always could ☐ Not quite as much now ☐ Definitely not so much now ☐ Not at all
5. Worrying thoughts go through my mind:
☐ A great deal of the time ☐ A lot of the time ☐ From time to time but not too often ☐ Only occasionally
6. I feel cheerful:
☐ Not at all ☐ Not often ☐ Sometimes ☐ Most of the time
7. I can sit at ease and feel relaxed:
☐ Definitely ☐ Usually ☐ Not often ☐ Not at all
8. I feel as if I am slowed down:
☐ Nearly all the time ☐ Very often ☐ Sometimes ☐ Not at all
9. I get a sort of frightened feeling like butterflies in the stomach:
☐ Not at all ☐ Occasionally ☐ Quite often ☐ Very often
10. I have lost interest in my appearance:
☐ Definitely ☐ I don't take so much care as I should ☐ I may not take quite as much care ☐ I take just as much care as ever
11. I feel restless as if I have to be on the move:
☐ Very much indeed ☐ Quite a lot ☐ Not very much ☐ Not at all
12. I look forward with enjoyment to things:
☐ As much as I ever did ☐ Rather less than I used to ☐ Definitely less than I used to ☐ Hardly at all
13. I get sudden feelings of panic:
☐ Very often indeed ☐ Quite often ☐ Not very often ☐ Not at all
14. I can enjoy a good book or radio or TV programs:
☐ Often ☐ Sometimes ☐ Not often ☐ Very seldom

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HIPAA ACKNOWLEDGEMENT

I understand that I have the right to review Dr. Attaman, PLLC Notice of Privacy Practices prior to signing this consent. I understand that Dr. Attaman, PLLC reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, Medicaid, DSHS, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The records may be needed in order to process a claim for medical services.

I authorize Dr. Attaman, PLLC to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories:

Patient Signature

Patient's Printed Name

Date

If Patient is unable to sign this Authorization, please complete the information below:

Signature of Guardian/Representative

Print Guardian/Representative Name

Date

RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

During the course of your treatment it may become necessary or desirable to discuss your condition with a family member or family friend. Below, please indicate with whom we may discuss your condition and/or treatment:

Print Family Member(s) or Friend(s) Name(s)

Date of Birth

PLEASE DO NOT DISCUSS MY TREATMENT WITH

Print Family Member(s) or Friend(s) Name(s)

Date of Birth

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

I presented this Acknowledgement to the patient. The patient refused to provide a signature when requested.

Staff Member Signature

Printed Name

Date

DR. ATTAMAN, PLLC

4701 SW ADMIRAL WAY #217, SEATTLE WA 98116

FAX: 888-688-4167 • PHONE: 206-395-4422 • nopain@soundinterventionalpain.com • jasonattaman.com

PART TWO

FINANCIAL POLICY

Thank you for choosing Dr. Attaman, PLLC for your care. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask. We ask that all patients read and sign our Financial Policy as well as complete our patient information forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, are due **at the time services are rendered**. We accept cash, personal checks, and credit cards for payment. We do our best to inform you of an estimated cost of services prior to your visit.

We accept assignment with most major insurance companies and participating provider plans (Premera Blue Cross, Regence Blue Shield, Medicare, Aetna, Cigna, First Choice, Humana, United Health Care, Labor and Industries/ Workers Compensation, Auto Insurance). However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier.
2. **All charges are your responsibility whether your insurance company pays or not.** Our company will accept financial responsibility for claims not filed correctly or in a timely manner IF YOU SUPPLY OUR COMPANY WITH CORRECT AND CURRENT DEMOGRAPHIC AND INSURANCE INFORMATION FOR ALL CLAIMS.
3. Fees for services, along with unpaid deductibles and co-payments, are **due at the time of treatment**.
4. If the insurance company does not pay your balance in full within 30 days we ask that you contact the carrier to request prompt payment. Please inform our company of the carrier's response.
5. Returned checks will be subject to a \$30.00 collection charge. If the check is not picked up and payment made within 10 days, we will turn the check over to law enforcement.
6. Balances over 60 days will be charged a handling fee. Unpaid balances over 90 days **will** be sent to collections via small claims court, attorney, and/or collection agency with applicable collection fees.
7. Failure to cancel an office/clinic appointment within 24 hours of the appointment **will** result in a cancellation or "no show" fee charge of \$50.00. Failure to cancel a pain injection procedure scheduled in a surgery center, hospital, or fluoroscopic suite within 24 hours of the appointment **will** result in a cancellation or "no show" fee charge of \$300.00.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Dr. Attaman, PLLC the medical and/or surgical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing. At such point I will become responsible for filing my insurance claims.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I authorize Dr. Attaman, PLLC to charge my credit card the appropriate "no show" fee as discussed above if I do not cancel an appointment within the requested time frame.

Signature of Patient or Legal Representative

Printed Name

Date

Credit Card Number

Expiration Date

Security
Code

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