Kyong Kim, DO – Alan Vo, DO
Kushal Dhesi, MD – Paul Bradley, PA-C
Locations in Tukwila, Covington, Lakewood & Silverdale

Patient Information

Last Name	First Name	MI

Date of Birth	Sex	Marital Status	Social Security Number

Mailing Address	City	State	Zip

Home Phone Number	Cell Phone Number	Work Phone Number

Email Address	Race/Ethnicity	Preferred Language

Employment Status? ❑ Full Time ❑ Part Time ❑ Unemployed ❑ Student	Employer

Referring Provider	Primary Care Provider

Emergency Contact Name	Relationship to Patient	Phone Number

Please read the following policies and initial next to each one to indicate your acknowledgement.

_____ **Cancellation Policy:** Puget Sound Pain Clinic requires a 24 hour notice (Mon-Fri) for appointment cancellation. There is a $75.00 fee for follow-up appointments that are cancelled without a 24-hour notice. There is a $100 fee for procedures that are cancelled without a 24-hour notice. If the patient doesn't not call or show up for their appointment, the same fees apply. If you acquire too many No Call/No Show's you may be discharged from our practice.

_____ **Initial Consultation:** Your first appointment is a consultation only to discuss your medical needs. Medication, narcotic or non-narcotic, is prescribed at the doctor's discretion. These services are NON-REFUNDABLE. **PRIVATE PAY/CASH PAY PATIENTS: You understand we are not obligated to prescribe medication in exchange of cash payment and will not refund money if you do not obtain a medication prescription.**

_____ **Opioid Therapy Policy:** PSPC takes a conservative approach to opioid therapy, typically prescribing a lower dose of medications. Research in results continue to demonstrate that a regimen of a higher dose can result in greater risk of physical dependency, tolerance and addiction versus a treatment plan that includes lower dosages of opioid medications that results in long- lasting positive outcomes. PSPC stringently follows the Federal DEA guidelines in recommendation for prescribing opioid medications.

_____**PSPC Code of Conduct:** I will treat the staff with courtesy and respect at all times, I understand PSPC has a zero-tolerance policy regarding rude, vulgar, profane or harassing comments or actions to any staff members. This will include repeated phone calls requesting, demanding medications, or early appointments with any staff. I understand if I exhibit any of this behavior, I will be discharge from this practice immediately.

____ **Medication History Consent for Medical Treatment:** Medication Prescription history is a list of medicine that PSPC and other Physicians have recently prescribed for a patient. It is collected from a variety of sources (patient's pharmacy, health plans, other Physicians and Washington State Pharmacy Board.) I authorize PSPC and any associates, assistants, and other healthcare Physicians to treat my condition. I understand that no guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. **I give PSPC consent to retrieve and review my medication history. I understand that this will be become part of my medical records.**

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PUGET SOUND PAIN CLINIC

Financial Agreement & Insurance Information

Is the condition you are being seen for related to a on the job injury or workers compensation claim?
❑ **YES** ❑ **NO**

Is the condition you are being seen for related to a motor vehicle accident?
❑ **YES** ❑ **NO**

Primary Insurance Information

Insurance Company	ID/Subscriber Number	Group Number
Subscriber's Name	**Subscriber's Date of Birth**	**Relationship to Patient**

Secondary Insurance

Insurance Company	ID/Subscriber Number	Group Number
Subscriber's Name	**Subscriber's Date of Birth**	**Relationship to Patient**

❑ If any payment is made directly to the patient for services billed by this office from my insurance, I recognize an obligation to promptly remit the same payment to Puget Sound Pain Clinic.

❑ You are ultimately responsible for payment of services rendered from our office (Co-pays, Deductibles, Balances, etc.). These must be paid prior to seeing the Physician or we will to reschedule your appointment. Monthly payments are required for outstanding balances. A $35.00 returned check fee applies for checks not honored by the bank.

❑ Puget Sound Pain Clinic will submit my insurance claim to contracted primary insurances and will forward (one time only) to my secondary insurance. They do not bill tertiary insurance. The balance of my account is due immediately upon payment or denial of the claim. Regardless of the insurance status, I am ultimately responsible for the balance of the account for which professional services are rendered. I understand that billing my insurance company does not guarantee payment. If Puget Sound Pain Clinic is not submitting a claim to an insurance company, payment at the time of service will be required unless a previous arrangement have been made with the Practice Administrator.

❑ Advance Beneficiary Notice – PSPC will make an effort to verify coverage and obtain pre-authorization/pre-determination for services rendered. However, we may require that an Advance Beneficiary Notice (ABN) be signed before certain services are provided. I authorize the release my medical records to obtain pre-authorization and/or process insurance claims.

❑ If you fail to make payments you are responsible for in a timely manner, after such default, Puget Sound Pain Clinic will send your account balance to a collection agency and/or attorney. You may be asked to seek medical care elsewhere. You will be responsible for all costs of collecting monies owed. This includes court costs, collection agency fees and attorney fees. A $50.00 fee will be added on all accounts placed in collections or with an attorney. Outstanding balances older than 60 days will begin to accrue a finance charge of 12% annually.

❑ It is the responsibility of you, the patient, to provide us with your current address, telephone numbers, and insurance information at the time of your initial visit and any other visits thereafter. In addition, it is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan.

❑ MVA (motor vehicle accident): We will bill the motor vehicle insurance company only if you bring in all information required. This includes insurance name, claim number, contact person and address to send the claims. We will call the insurance to verify that you have medical coverage. If there is no information on your claim on the date of service, you may be billed, or we will accept commercial insurance in case of denial.

❑ **I HAVE READ THE ABOVE AND UNDERSTAND PSPC POLICIES AND FINANCIAL INFORMATION AS SET FORTH**
I have provided Puget Sound Pain Clinic with true, accurate and complete information for billing and insurance coverage. I agree to notify PSPC of any changes in address, billing or contact information in a timely manner. **Release of Benefits:** I authorize my insurance benefits be paid directly to the provider of service. I am financially responsible for any balance due. I authorize PSPC to release any information required for payment of claim.

Patient Signature: **Date:**

Dear Patient,
HIPAA law protects the use and disclosure of all patient information. In order for us to contact you to remind you of appointments, discuss any financial matters or even speak with your family; we need authorization on file from you. Please review the situations below in which we may use your information to contact you.

❑ Reschedule or remind you of an appointment.
❑ Obtain or update insurance information on file.
❑ Discuss or inform you of any financial arrangements, benefits, or account issues.
❑ Medication Prescription Information.
❑ Leave detailed voicemails.

If you are not available, please list below any other person(s) whom you are authorizing us to contact regarding the above information. Under HIPAA law, you may change your authorization by notifying our office in writing.

Name	Relationship	Phone Number

❑ **I do NOT wish to release my medical information to anyone other than myself NAME**

Notice of Privacy Practices

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Federal law requires us to provide you with a notice of privacy practices, which is our explanation of how we use and disclose your health information. We ask you to acknowledge that you have received this notice.

❑ A copy of the Notice of Privacy Practices of Puget Sound Pain Clinic is providing in the lobby for my review. I am aware that I can obtain a copy of this Notice at any time.

❑ You have the right to review our notices before signing this acknowledgement. If you have any questions, ask for an explanation about any part of the notice, or any other aspects of our use and disclosure of your health information. The terms of our notice may change as the law and our practice changes. I understand that if any changes made to our Privacy Practices, a notice will be provided in the main waiting room area Puget Sound Pain Clinic.

❑ I understand that if I have any questions with regard to this Notice of Privacy Practices, I may also contact Puget Sound Pain Clinic in writing to the Practice Administrator at the following address:

Puget Sound Pain Clinic
11306 Bridgeport Way SW Suite D
Lakewood, WA 98499
Phone (253) 983-9390
Fax (253) 983-0066

By signing this form, I acknowledge that I have had the opportunity to review's PSPC Notice of Privacy Practices which are displayed for public inspection in PSPC facility. The notice describes how my protected health information may be used or disclosed and how I may access my health records. I authorize PSPC to release my protected health information (medical records) in accordance to their Privacy Practices. We appreciate you signing this form, which acknowledges that you have received or have been offered and refused a copy of our Privacy Practice notice.

Patient Signature: **Date:**

PUGET SOUND
PAIN CLINIC

Authorization to Release Information

Patient Name: (Please Print)	Date Of Birth	Social Security Number

PSPC MAY RELEASE MY INFORMATION TO:

Name:	
Address:	
Phone Number:	Fax Number:

PSPC MAY RECEIVE MY INFORMATION FROM:

Name:	
Address:	
Phone Number:	Fax Number:

INFORMATION TO BE RELEASED:

❑ The most recent 2 YEARS of Pertinent Information (Chart Notes, Lab Reports, Radiology, Special Tests, etc.)
❑ All Medical Records
❑ Specific Information (Please Specify):_____

Purpose for which information is being released (check one):

❑ Attorney ❑ Insurance Provider ❑ Personal ❑ Other (Please Specify):_____

This Authorization Will Expire On (Date or Specific Event): _____.
If no date/event is given, the authorization shall expire **90 DAYS** from the date signed. Possible copying fee required.

My Rights: 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. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

PATIENT SIGNATURE: _____ DATE: _____
* If not listed on patient release of information medical records. Patient, Guardian, or Authorized Representative *Please provide documentation to prove authority to sign on behalf of the patient.