MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to the Washington Center for Pain Management. When you schedule an appointment with WCPM we set aside time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible.

Please see our Appointment Cancellation/No Show Policy below:

Any patient who fails to show or cancels/reschedules an office visit and has not contacted our office with at least **48 business hours** notice will be charged a **$150 fee**.

Any patient who fails to show or cancels/reschedules a procedure and has not contacted our office with at least **48 business hours** notice and will be charged a **$200 fee.**

The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, when time allows, we will send appointment reminders by text or phone. If you do not receive a reminder message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your appointment. One time requests for fee waivers can be emailed to: **billing@washingtonpain.com** or mailed to: **WCPM, PO Box 827, Bellevue WA 98009**. Requests without supporting documentation will not be considered. Examples of supporting documents: Urgent care or ER discharge, tow bill, accident report.

The billing department does not accept calls to discuss cancellation or no show fees.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature Date

_____ _____

Patient Name DOB

HIPAA AUTHORIZATION FORM FOR FAMILY MEMBERS/FRIENDS

I understand that my family members and friends may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties below with whom I wish WCPM to be able to discuss my medical condition.

Name: **Relationship:**

_____ _____

_____ _____

_____ _____

_____ _____

Health Information to be verbally disclosed (Initial all that apply):

Appointments/Scheduling _____

Billing _____

Discuss medication and medical care _____

Request and pick up/fax prescriptions/forms _____

Emergency Contact:

Name _____ Phone Number _____

I DO ____ DO NOT ____ GIVE PERMISSION for WCPM to **leave information on my answering machine and/or with family members and friends at the following phone number(s):** _____ _____ in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on the answering machine or with family members.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subjected to redisclosure by the above recipient.

I understand that I have the right to revoke this authorization at any time in writing. I understand that any revocation will be effective only to the extent that the WCPM has not already disclosed my PHI based on this Authorization.

Patient Name DOB

_____ _____

Patient Signature Date

_____ _____

THE
WASHINGTON CENTER
FOR PAIN MANAGEMENT

INSURANCE INCIDENT REPORT FORM

Patient Name (print): _____ DOB:_____

Why are you coming to see us? (Area of pain) _____

Is your pain related to any type of injury?

YES **(if yes, complete form in full)** **NO** **(if no, skip to end and sign)**

If so, what type? **JOB/WORK** **AUTO** **OTHER**: _____

Did you open a claim for this injury? **YES** **NO (If no please open a claim by logging onto www.lni.wa.gov for work related injuries or call your auto insurance provider)**

Is your claim still open/active? **YES** **NO** UNSURE

Are you trying to reopen your claim? **YES** **NO**

Regardless of your claim status we do require the following information to verify your claim status and submit any claims to your private insurance (if applicable). Even if the claim has been closed for some time period most insurance will deny claims if these claims are not verified as closed. Failure to provide this information or giving false information regarding any injury is fraud. It is your right and responsibility to open a claim for these types of injury. If you are unsure you must provide this information before receiving services.

Claim number: _____ Name of Insurance Company: _____

Claim Manager/Claim Adjuster name: _____

Claim Manager/Claim Adjuster phone number: _____

Claim Manager/Claim Adjuster Fax Number: _____

Date of injury: _____/_____/_____ State of Injury: _____

Place of injury (Company working for): _____

Attending Physician/Referring Provider: _____

Attending Physician/Referring Provider phone: (_____) _____

Attending Physician/Referring Provider Fax: _____

Additional Information relating to your claim: _____

Signature: _____ Date: _____

THE
WASHINGTON CENTER
FOR PAIN MANAGEMENT

PO Box 827
Bellevue, WA 98009
P. 425-774-1538
F. 877-809-6099

Patient Name: _____ D.O.B: _____

Allergies and Reactions: _____.

Medication List

Medication	Dosage	Frequency	Reason for Taking

Past Medication Intake Sheet Name: _____

Select the Past Medications You Have Tried or Failed

Neuropathic Pain Medications

Gabepentin (Neurontin)	Helped	Did Not Help	Had A Reaction_____
Pregabalin (Lyrica)	Helped	Did Not Help	Had A Reaction_____
Duloxetine (Cymbalta)	Helped	Did Not Help	Had A Reaction_____
Amitriptyline (Elavil)	Helped	Did Not Help	Had A Reaction_____
Nortriptyline (Pamelor)	Helped	Did Not Help	Had A Reaction_____
Venlafaxine (Effexor)	Helped	Did Not Help	Had A Reaction_____
Milnacipran (Savella)	Helped	Did Not Help	Had A Reaction_____

NSAIDS & Acetaminophen

Naproxen (Naprosyn)	Helped	Did Not Help	Had A Reaction_____
Ibuprofen (Advil/Motrin)	Helped	Did Not Help	Had A Reaction_____
Diclofenac (Zipsor/Cambia/Voltaren)	Helped	Did Not Help	Had A Reaction_____
Meloxicam (Mobic)	Helped	Did Not Help	Had A Reaction_____
Celebrex (Celecoxib)	Helped	Did Not Help	Had A Reaction_____
Acetaminophen (Tylenol)	Helped	Did Not Help	Had A Reaction_____

Opioids

Codeine	Helped	Did Not Help	Had A Reaction_____
Tramadol (Ultram)	Helped	Did Not Help	Had A Reaction_____
Oxycodone (Percocet/Endocet)	Helped	Did Not Help	Had A Reaction_____
Hydrocodone (Vicodin)	Helped	Did Not Help	Had A Reaction_____
Hydromorphone (Dilaudid)	Helped	Did Not Help	Had A Reaction_____
Morphine	Helped	Did Not Help	Had A Reaction_____
Oxymorphone (Opana)	Helped	Did Not Help	Had A Reaction_____
Methadone (Dolophine)	Helped	Did Not Help	Had A Reaction_____
Buprenorphine (Butrans/Suboxone)	Helped	Did Not Help	Had A Reaction_____
Fentanyl Patch (Duragesic)	Helped	Did Not Help	Had A Reaction_____

Muscle Relaxants

Tizandidine (Zanaflex)	Helped	Did Not Help	Had A Reaction_____
Cyclobenzaprine (Flexeril)	Helped	Did Not Help	Had A Reaction_____
Methocarbamol (Robaxin)	Helped	Did Not Help	Had A Reaction_____

Membrane Stabilizers

Lamotrigine (Lamictal)	Helped	Did Not Help	Had A Reaction_____
Topiramate (Topamax)	Helped	Did Not Help	Had A Reaction_____

Migraine Medications

Triptans (Suma-, Riza-)	Helped	Did Not Help	Had A Reaction_____
Beta Blockers (-lols)	Helped	Did Not Help	Had A Reaction_____
Rimegepant (nurtec)	Helped	Did Not Help	Had A Reaction_____

*Please proceed to the back

Patient Initials _____ **DOB**:_____

Migraine Medications Cont.

Eptinezumab (Vyapti)	Helped	Did Not Help	Had A Reaction_____
Fremanezumab (Ajovy)	Helped	Did Not Help	Had A Reaction_____
Galcanezumab (Emgality)	Helped	Did Not Help	Had A Reaction_____
Lasmiditan (Reyvow)	Helped	Did Not Help	Had A Reaction_____

Patient Name:_____ Date of Birth: _____

SOAPP-R Questionnaire

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐
13. How often have any of your close friends had a problem with drugs or alcohol?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐

Patient Initials:_____ Date of Birth: _____

16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for a drug or alcohol problem?	☐	☐	☐	☐	☐

Total Score: _____

All 24 questions contained in the SOAPP-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

THE
WASHINGTON CENTER
FOR PAIN MANAGEMENT

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name (PRINT)	Date of Birth	Phone Number	Last 4 digits of Social Security #
_____	_____	(____)_____	____ ____ ____ ____

YOU MAY RELEASE MY INFORMATION FROM:

_____ _____
Clinic Provider Name

_____
Address

_____
City, State, Zip

(____)_____ (____)_____
Fax Phone

YOU MAY RELEASE MY INFORMATION TO:

_____
Name (i.e. Attorney, Provider, Self)

_____
Address

_____
City, State, Zip

(____)_____ (____)_____
Fax Phone

INFORMATION TO BE RELEASED:

☐ The most recent **2 YEARS** of pertinent information **(Chart notes, lab reports, x-rays reports and special tests)**
☐ All medical records
☐ Specific information **(Please specify)**: _____

PURPOSE FOR WHICH INFORMATION IS BEING RELEASED (CHECK ONE):

☐ Attorney ☐ Insurance ☐Provider ☐Personal ☐Other (specify):_____

DELIVERY PREFERENCE (CHECK ONE):

☐ Mail Paper Copy ☐ Mail CD ☐Email (Patient requests only): _____
(Please provide a legible email address)

Patient Authorization:
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:
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 to patients 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.

SIGNATURE: _____ **DATE**: _____
Patient, Guardian*, or Authorized Representative
***Please provide documentation to prove authority to sign on behalf of the patient.**

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.

Health Information Department