Olympic Spine & Sound Pain Solutions
6603 220th St. SW Ste. 102
Mountlake Terrace,
WA 98043
425-774-2411

OLYMPIC
SPINE & SOUND PAIN SOLUTIONS

Welcome to Olympic Spine & Sound Pain Solutions! At your first appointment you will be meeting with the doctor for your complimentary consultation. The doctor will review your history, current symptoms, and perform a screening examination to determine if it's likely youare a candidate for our treatment procedures. If you are a candidate for treatment, the doctor will make recommendations for a comprehensive examination, testing, x-rays, and/or treatment; these are not covered in your complimentary consultation. If you choose to receive additional examination, testing, and/or treatment, you will incur normal charges.

**Comprehensive examination, testing, x-rays, and/or treatment are not included in your complimentary consultation.**

It is our desire that no one is denied health care due to finances. If a patient makes their healthcare a priority, we will work with them to make arrangements that also work financially.

Respectfully yours,

Kaiya Hunsaker

Office Manager

Please sign this letter to indicate that you have completely read and understood its contents.

Print Name_____Date _____

**Signature** _____

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# Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Name Printed:_____ ID #: _____

**Patient Signature:**_____ **Date:** _____

Authorization to Release Information to Physician

At Olympic Spine & Sound Pain Solutions, we believe it is important that all your physicians worktogether for your benefit. By signing this release, you are authorizing us to release reports and information to your doctor(s) regarding your treatment at Olympic Spine & Sound Pain Solutions.

Patient Signature:_____ Date: _____

**Authorization to Release Information to Designated Individuals**

I authorize that Olympic Spine & Sound Pain Solutions can share my healthcare information with the following individuals:

Name:_____ Relationship to Patient: _____

**Name:**_____ **Relationship to Patient:** _____

**Patient Signature:**_____ **Date:** _____

**Office Use Only**

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____Attempt_____

Staff Name_____

# Olympic Spine & Sound Pain Solutions

**(Staff only) MRN OPS:_____ OSST:_____ Reviewed w/Patient: _____/_____**

Last Name:_____ First Name:_____ Date: ___/____/___

DOB: _____ Sex: M | F | Marital Status: _____ Spouse/Significant Other: _____

Primary Care Provider: _____ Occupation: _____

**(Minors only)** Name of parent/guardian:_____ Phone # (if different): _____

Address: _____City: _____State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____ Email: _____

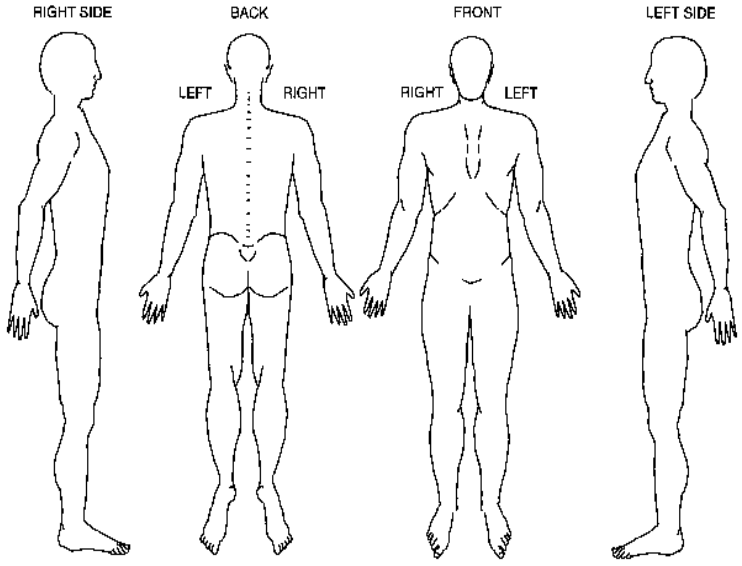
**EMERGENCY CONTACT**: Contact Name:_____ Phone:_____

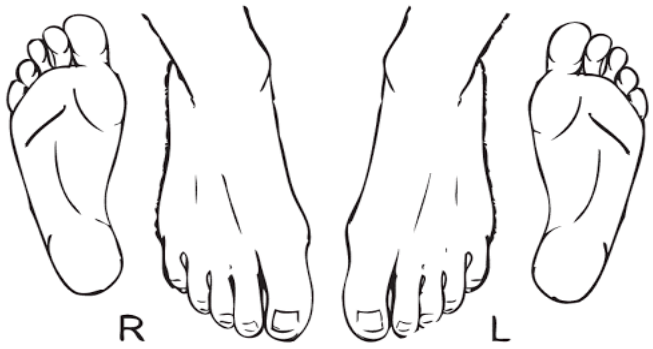
Are we authorized to release your medical information to the listed emergency contact? **Yes** or **No**

How did you hear about our clinic? _____

**CHIEF COMPLAINTS: On the diagrams, please mark where you are experiencing any symptoms**

**Use the following as a guide:** P = Pain T = Tingling N = Numbness B = Burning W = Weakness




Describe the symptoms & location you are experiencing them. Rate on a scale of 0-10 (0= no discomfort, 10= worst imaginable).

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Example**: Tingling in right foot _____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Symptom #1:_____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Symptom #2:_____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Symptom #3:_____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Symptom #4:_____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| Symptom #5:_____ | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

When did your symptoms begin?_____ How often do you have this symptom?_____
Is it constant or does it come and go? _____Are the symptoms getting progressively worse? **Yes | No | Unknown**

Does the pain radiate ("shooting down" or "shooting up")? **Yes | No** If so, where does the pain radiate?_____
_____

How would you characterize your symptom? (Circle all that apply): **Dull | Sharp | Achy | Shooting | Burning | Stabbing Throbbing | Stiffness | Numb**
**Other**_____

What makes your condition worse? (Circle all that apply): **Coughing | Sneezing | Bearing Down | Lifting | Bending Driving | Cold/Hot Weather | Sitting | Standing | Lying Down | Walking | Moving Your Head | Bowel Movement**
**Other**_____

What makes your condition better? (Circle all that apply): **Rest | Movement | Sitting | Standing | Lying Down | Physical Therapy | Heat | Ice | Massage | Stretching | Over-the-counter Medication | Prescribed Medication | Injections**
**Other**_____

What time of the day are your symptoms worse? (Circle all that apply): **Morning | Afternoon | Evening | Sleeping | At Work | Other**_____

What time of the day are your symptoms better? (Circle all that apply): **Morning | Afternoon | Evening | Sleeping | At Work | Other**_____

Is there any known cause of your symptoms? (Circle all that apply): **Auto Accident | Work Injury | Lifting | Slip/Fall**

**Overexertion | Strenuous Position | Unknown | Other** _____

If known cause, how soon did symptoms start?(Circle) **Immediately | Hours Later | Next Day | Days Later | Week Later**

Is there any color change or temperature change to the skin?: **Yes | No** _____

When your symptoms are at their worst, describe what happens: _____
_____

Have you experienced symptoms like these before?: **Yes | No (when?)** _____
Have you missed any work due to this condition?: **Yes | No (dates?)** _____
Have you had to modify or restrict your activities at work? **Yes | No (restrictions?)** _____

**Previous Testing:**

Have you had any of the following testing?

X-ray: Y/N Area: _____ Date: _____ MRI: Y/N Area: _____ Date: _____

CT Scan: Y/N Area: _____ Date_____ EMG/NCV: Y/N Area: _____ Date: _____

Was there a previous diagnosis for your condition? i.e. Have you been told what is causing your problem? _____
_____

Treatment Options:

Is there any type of treatment that you would not consider at this time? _____
_____

What is your most important treatment objective? (Reduce pain, increase function, correct cause, prevent progression) _____

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

## LIFESTYLE & HABITS:

Average amount of sleep per night (hours): (Circle) **0 1 2 3 4 5 6 7 8 9 10 11 12+**
How often do you typically wake up at night? (Circle) **0 1 2 3 4 5+ times**

Are you awakened due to pain? If yes, how often: _____

Smoking (packs/day): (Circle) **Never 1 2 3 4+ Quit_____ years ago.** Caffeinated drinks (cups/day): **0 1 2 3 4 5 6+**

Alcohol consumption (drinks per day): (Circle) **0 1 2 3 4 5 6+** Drug/Substance use: **Yes | No _____**

Exercise (times per week): (Circle) **0 1 2 3 4 5 6 7** Type of exercise: _____

What do you feel your stress level is currently? (0 being no stress and 10 being maximal stress)
**1 2 3 4 5 6 7 8 9 10**

What three things has this condition caused you to miss out on the most?

1) _____ 2) _____ 3) _____

## PREVIOUS TREATMENT / ACCIDENTS / HOSPITALIZATIONS:

☐ Physical Therapy | Location?: _____ Date of last PT: _____ Duration: _____

☐ Acupuncture: _____ ☐ Psychotherapy:_____ ☐ Chiropractor : _____

☐ Tens _____ ☐ Injections _____ Failed Treatments/Other: _____

☐ Prescription Medications _____

Have you been told you need an injection? YES NO _____

Have you been told you need spinal surgery? YES NO _____

*(Please inform us of any/all recent injuries that could have contributed to your current condition.)*

Do you have a history of any of the following? (Circle) **Work Injury | Auto Accident | Slip & Fall Accident**
If so, please list approximate dates and incident:

1. Date____/____/____Incident _____
2. Date____/____/____Incident _____

Have you ever been hospitalized? **Yes | No** If so, when and for what condition?

1. Date____/____/____Condition _____
2. Date____/____/____Condition _____

Have you had any surgeries? **Yes | No** If so, when and for what condition?

1. Date____/____/____Surgery _____
2. Date____/____/____Surgery _____

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

## REVIEW OF SYSTEMS:

**Do you currently have any of the following?**

**(Circle all that apply)**

**General:** Weight loss | Weight gain | Fever | Fatigue | Loss of appetite | Nausea | Vomiting

**Cardiovascular:** Chest pain | Chest pressure |Shortness of breath | Irregular heartbeat | Murmur

**Respiratory:** Coughing | Difficulty breathing Asthma/wheezing | Coughing up blood

**Gastrointestinal:** Constipation | Diarrhea | Heartburn Bloody stool | Pain in stomach | Ulcers | Hepatitis

**Eyes**: Vision problem | Glaucoma | Blurred vision | Double vision | Glasses | Eye pain

**ENT:** Ear pain | Hearing loss | Ear noises |Nosebleed Sore throat | Hoarseness | Dental issues | Difficulty swallowing

**Psychiatric:** Depression | Anxiety | Panic attack | Suicide attempts | Suicidal thoughts| Homicidal thoughts|

**Hematology:** Anemia | Blood disorders

**Musculoskeletal:** Arthritis | Joint pain | Swelling in legs or arms | Back pain | Neck pain | Muscle pain | Muscle spasms/cramps | Muscle weakness | History of broken bones | Recent falls

**Skin:** Skin problems | Rash | Slow healing | Easy bruising | Itching |Yellow or thick toenails

**Neuro**: Lightheaded/dizzy | Fainting | Weakness | Stroke | Tremors | Seizures | Memory loss | Sensation changes to skin (burning/tingling/numb)

**Genitourinary:** Painful urination | Frequent urination Bloody urine | Incontinence | Sexual difficulty | Frequent urinary tract infections

**Endocrine:** Excessive thirst |Excessive hair growth | Unexplained hair loss | Unexplained weight changes

### WOMEN ONLY:

Any chance of pregnancy? Y/N

Is there any chance that you may be PREGNANT? Y/N
Date of last menstrual period _____/_____/_____

**Have you had any of the following in the last 3 months? (Check all that apply)**

☐ Neck Pain ☐ Wrist Pain ☐ Upper Back Stiffness ☐ Low Back Pain ☐ Hip Pain

☐ Neck Stiffness ☐ Elbow Pain ☐ Mid Back Pain ☐ Low Back Stiffness ☐ Knee Pain

☐ Shoulder Pain ☐ Upper Back Pain ☐ Mid Back Stiffness ☐ Leg Pain ☐ Ankle Pain ☐ Foot Pain

## Vascular Screening:

Have you recently experienced any of the following? (mark all that apply):

☐ Double Vision / Sudden Onset of Vision Problems

☐ Dizziness, Vertigo or Light-headedness

☐ Sudden Numbness/ Weakness of Face, Arms or Legs

☐ Difficult Speaking

☐ Difficulty Swallowing

☐ Difficulty Walking

☐ Nausea, Vomiting, or Queasiness

☐ Numbness or Loss of Sensation on one side

☐ Involuntary Rapid Eye Movements (nystagmus)

☐ None of the above

☐ If you are experiencing Headaches or Neck Pain, have you experienced pain like this before?

☐ Yes, I have had headaches / neck pain like this before.

☐ No, this pain is different than I have experienced in the past. ☐ Did your headache or neck pain start suddenly?

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

## PAST MEDICAL HISTORY:

**Have you ever had any of the following? (Circle all that apply)**

**Heart:** Coronary artery disease | Hypertension Murmurs | Valvular disease | Aneurysm | High cholesterol || Heart failure Angina | Stents Other:_____

**Gastrointestinal:** Ulcer | Reflux | Gastritis | Hepatitis | Liver disease | Cancer | Bleeding | Diverticulosis | Other: _____

**Neuro:** Stroke | Aneurysm | Brain cancer | Nerve injury Spinal cord injury | Alzheimer's | Dementia | Seizures Parkinson's | Other:_____

**Kidney:** Failure | Stones | Dialysis | Kidney stents Other:_____

**Lungs:** Asthma | COPD | Emphysema | Bronchitis | TB Pneumonia | Lung cancer | Other:_____

**Endocrine:** Diabetes | Hypothyroidism Hyperthyroidism | Other:_____

**Psychiatric:** Depression | Bipolar | Anxiety | Panic disorder | OCD| Schizophrenia | ADD/ADHD Other:_____

**Bone/Muscular:** Arthritis | Rheumatoid arthritis | Gout | Osteoporosis | Osteopenia | Scoliosis | Fibromyalgia Other:_____

**Cancer:** _____

**Do you have a Pacemaker/Defibrillator or Spinal Cord Stimulator? _____**

**Other:** _____

## ALLERGIES / MEDICATIONS / SUPPLEMENTS:

| Prescription Medications | Supplements | Allergies |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

☐ **List of Medications Attached**

Do you take any form of blood thinners, including daily aspirin? _____

## FAMILY HISTORY

Has any member of your family been diagnosed with any of the following? **(Circle all that apply)**

Cancer | Diabetes | High Blood Pressure | Stroke | Heart Disease | Hypertension | Depression | Spinal Pain
Other: _____ If yes, what is their relation to you? _____ **Father side | Mother side | Siblings**

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

# Additional Information & Resources

*If you are interested in receiving additional information about any of the following,please check the boxes below:*

## Conditions

- ☐ Peripheral Neuropathy
- ☐ Sciatica
- ☐ Chronic Headaches
- ☐ Dizziness/ Balance Disorders
- ☐ Whiplash Injuries
- ☐ Mild Traumatic Brain Injury
- ☐ Chronic Back/Neck Pain
- ☐ Joint Pain (Hip, Knee, Foot, Shoulder, Elbow, Hand)
- ☐ Carpal Tunnel Syndrome

## Treatment

- ☐ Non-Surgical Decompression
- ☐ Non-Invasive Laser
- ☐ Clinical Nutrition
- ☐ Functional Neurology
- ☐ Vitamins / Supplements
- ☐ Bioelectrical Therapy
- ☐ Trigger Point Injections
- ☐ PRP (Platelet Rich Plasma Injections) Injections
- ☐ Physical Rehabilitation

**THIS FORM IS COMPLETED BY**:

Patient Name: _____ Date: _____

Patient Signature: _____

Authorized Representative: _____ Date: _____

Signature of Authorized Representative: _____

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

# LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

## Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

## Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

## Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, butI can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenientlypositioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

## Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

## Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by

10. A score of 22% or more is considered significant activities of dailyliving disability.

## Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

## Section 7 – Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

## Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart fromlimiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out asoften.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

## Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor orhospital.

## Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slowat the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

**Comments**_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook.In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation& Education. Manchester Univ Press, Manchester 1989: 187-204

**Name: _____ DOB: _____ MRN: OPS_____ / OSST: _____**

# NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT -DAY SITUATION.

## SECTION 1 - PAIN INTENSITY

- ☐ **I have no pain at the moment.**
- ☐ **The pain is very mild at the moment.**
- ☐ **The pain is moderate at the moment.**
- ☐ **The pain is fairly severe at the moment.**
- ☐ **The pain is very severe at the moment.**
- ☐ **The pain is the worst imaginable at the moment.**

## SECTION 2 - PERSONAL CARE

- ☐ **I can look after myself normally without causing extra pain.**
- ☐ **I can look after myself normally, but it causes extra pain.**
- ☐ **It is painful to look after myself, and I am slow and careful.**
- ☐ **I need some help but manage most of my personal care.**
- ☐ **I need help every day in most aspects of self -care.**
- ☐ **I do not get dressed. I wash with difficulty and stay in bed.**

## SECTION 3 – LIFTING

- ☐ **I can lift heavy weights without causing extra pain.**
- ☐ **I can lift heavy weights, but it gives me extra pain.**
- ☐ **Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.**
- ☐ **Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.**
- ☐ **I can lift only very light weights.**
- ☐ **I cannot lift or carry anything at all.**

## SECTION 4 – WORK

- ☐ **I can do as much work as I want.**
- ☐ **I can only do my usual work, but no more.**
- ☐ **I can do most of my usual work, but no more.**
- ☐ **I can't do my usual work.**
- ☐ **I can hardly do any work at all.**
- ☐ **I can't do any work at all.**

## SECTION 5 – HEADACHES

- ☐ **I have no headaches at all.**
- ☐ **I have slight headaches that come infrequently.**
- ☐ **I have moderate headaches that come infrequently.**
- ☐ **I have moderate headaches that come frequently.**
- ☐ **I have severe headaches that come frequently.**
- ☐ **I have headaches almost all the time.**

**SCORE _____ [50]**

## SECTION 6 – CONCENTRATION

- ☐ **I can concentrate fully without difficulty.**
- ☐ **I can concentrate fully with slight difficulty.**
- ☐ **I have a fair degree of difficulty concentrating.**
- ☐ **I have a lot of difficulty concentrating.**
- ☐ **I have a great deal of difficulty concentrating.**
- ☐ **I can't concentrate at all.**

## SECTION 7 – SLEEPING

- ☐ **I have no trouble sleeping.**
- ☐ **My sleep is slightly disturbed for less than 1 hour.**
- ☐ **My sleep is mildly disturbed for up to 1-2 hours.**
- ☐ **My sleep is moderately disturbed for up to 2-3 hours.**
- ☐ **My sleep is greatly disturbed for up to 3-5 hours.**
- ☐ **My sleep is completely disturbed for up to 5-7 hours.**

## SECTION 8 – DRIVING

- ☐ **I can drive my car without neck pain.**
- ☐ **I can drive as long as I want with slight neck pain.**
- ☐ **I can drive as long as I want with moderate neck pain.**
- ☐ **I can't drive as long as I want because of moderate neck pain.**
- ☐ **I can hardly drive at all because of severe neck pain.**
- ☐ **I can't drive my care at all because of neck pain.**

## SECTION 9 – READING

- ☐ **I can read as much as I want with no neck pain.**
- ☐ **I can read as much as I want with slight neck pain.**
- ☐ **I can read as much as I want with moderate neck pain.**
- ☐ **I can't read as much as I want because of moderate neck pain.**
- ☐ **I can't read as much as I want because of severe neck pain.**
- ☐ **I can't read at all.**

## SECTION 10 – RECREATION

- ☐ **I have no neck pain during all recreational activities.**
- ☐ **I have some neck pain with all recreational activities.**
- ☐ **I have some neck pain with a few recreational activities.**
- ☐ **I have neck pain with most recreational activities.**
- ☐ **I can hardly do recreational activities due to neck pain.**
- ☐ **I can't do any recreational activities due to neck pain**

**BENCHMARK -5 = _____**

## FINANCIAL DISCLAIMER

The following is an explanation of what to expect and be aware of when it comes to the financial aspect ofyour treatment at Olympic Spine & Sound Pain Solutions.

You are legally responsible for your bill at the time you receive services from the clinic. You are ultimatelyresponsible for ensuring that the clinic is reimbursed for the services that we provided to you.

Co-pays are due at time of service. Payment options for a treatment plan will be presented to you after yourclinical Report of Findings.

If you have insurance we are not contracted with, we reserve the right to not bill it.

If you have insurance we are contracted with, we will bill it for covered services. Because policies are often customized per plan, we cannot always be sure what your insurance requires of you, which is why we will alsoverify coverage and benefits as a courtesy to you. Please note that insurance companies consistently issue thedisclaimer that quoted benefits are not a guarantee of payment. Please be sure to provide all current insurance info that you would like to be billed. Olympic Spine & Sound Pain Solutions is responsible for submitting an accurate bill to your insurance company. We recommend that you make yourself aware of whatyour insurance covers. If you would like a template for questions to ask your insurance, we will provide one upon request. Please note: Non-covered services, services that do not meet your insurance's criteria of medical necessity, or services that exceed the benefit maximum, will be your financial responsibility.

We do our best to make our patients aware when an insurance company doesn't process claims the way wewere told; however, it is the patient's responsibility to make sure his/ her insurance is processing claims correctly. Your insurance company is responsible for sending you an explanation of benefits (EOB) when it processes claims. If you have any questions regarding information on the EOB, please call your insurance company for details. Your insurance company is responsible for acting in your best interests by paying or declining to pay within a certain number of days from when claims were billed.

It is your responsibility to provide any required information (referrals, authorization numbers, claim forms, accident information). It is also your responsibility to follow the policy guidelines of your insurance company.Policies vary widely on which provider types, procedures, services, or items an insurance company will cover.

If your insurance changes, or if you are involved in an automobile or work accident, please inform us immediately. This allows the clinic to bill correctly, and to follow the required directions of your insurance. Ifyou do not tell us about a change to your insurance within two weeks of the change, a $20 charge will be added to your account for additional administrative work.

Due to the large number of patients and treatments performed, we do not provide monthly statements. If you would like a monthly statement, please make the request with the Front Desk staff.

If your insurance companypays your account in full, you will not receive a bill from us unless you specifically request a copy. If our recordsindicate that you have a balance after your insurance pays, you will receive a statement indicating your account balance. It is Olympic Spine & Sound Pain Solutions policy to send statements for up to 12 months after your last date of service. This can be due to the time it takes for all claims to be processed accurately.

The consultation and initial exam fees range from $88.00 to $443.00; X-Ray fees range from $66.00 to $279.00,and individual treatment fees range from $32.00-$375.00.

Cancellation/ Missed Appointment Policy: We require 24 hours' business day notice for any massage andphysical rehabilitation appointments, or you will incur a missed appointment fee of $45.

The patient is responsible for paying an administrative fee for any extra reports and/ or medical records not requested by the insurance company (For example: disability forms, work restriction reports, etc.). Since thesereports are not required to process your insurance claim, they are not billable to insurance and the financial responsibility is yours.

**AUTHORIZATIONS:**

I hereby authorize release of any medical information necessary to prepare and submit claims. I authorize payment of any medical benefits from third parties for claim submitted to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out ofproceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier andmyself. I understand that if I have insurance, the fees for services I receive will be billed to my insurance company. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be due and payable.

I have read and understood all statements on this document.

I, _____, have read and understand the terms and conditions stated above.

Signature

Patient Name:_____Date:_____ID: _____

Printed Office