Pacific Center for Neurostimulation

OFFICE POLICIES

This document explains the policies and conditions of Pacific Center for Neurostimulation PLLC. Please read it carefully and keep a copy for your records. Any of our providers or staff will be happy to answer any questions or provide clarification.

Description of Practice: Our practice consists of three board certified psychiatrists who specialize in performing transcranial magnetic stimulation (TMS).

Hours and Appointments: Office hours are by appointment. An initial consultation is 60 to 90 minutes, depending upon complexity. The initial transcranial magnetic stimulation session involves determining your motor threshold and typically takes 45 minutes to one hour. Subsequent transcranial magnetic stimulation sessions are 25 to 30 minutes. During an intensive TMS series, patients are typically seen weekly in the clinic for a 30 to 45 minute follow-up appointment with one of our clinicians.

New Patients: The first step in determining if TMS is an appropriate treatment for you is a thorough assessment. One of our physicians will meet with a new patient for 1-2 visits for an evaluation process. It is very helpful to have prior treatment records from your current and past psychiatric providers. We will discuss in depth your current situation, history, and treatment up to this point. After this evaluation, we will discuss a treatment plan and decide together on whether TMS is the best treatment option for you.

Patient Care Requirements: For the best results and coordination of care, we require that all patients have a primary psychiatric provider throughout the duration of TMS treatment. If at any point during your treatment you find that you will be losing this provider, you must re-establish with a new provider in order to continue your TMS program with us.

Fees: An initial evaluation is $500. A follow up visit varies based on the time of visit and the complexity of the condition. The initial TMS determination of motor threshold is $600. Subsequent TMS treatment sessions are $500. Consultative phone calls with our psychiatrists are based on a $300/hr rate, billed at 15 minute increments.

Cancellations: Appointment times are reserved for you, and we request a minimum of 48 hours notice if you need to cancel an appointment. Appointments missed or canceled less than 48 hours in advance, as well as non-cancelled and missed appointments, will result in a fee of $150.

Payment: We are contracted providers with Regence Blue Shield and Premera Blue Cross. For all other insurances payment is due at the time of service, unless other arrangements are made. We are not contracted providers with Medicare.

Emergencies and Coverage: One of our physicians is on call daily Monday through Friday during regular business hours for urgent issues related to TMS and can be reached by calling the main clinic number. For urgent issues after hours you may call your primary psychiatric provider's emergency line, if established. In the event of a psychiatric or medical emergency, you should call 911, go to the nearest emergency room, or call the King County Crisis Clinic at (206) 461-3222.

Patients' Rights: You have the right to be an active participant in decisions regarding your evaluation and treatment. You have the right to refuse evaluation or treatment, the right to change your provider and/or to receive a referral to another mental health provider.

Pregnancy: Although TMS is believed to pose no significant risk to a developing fetus, this has not yet been definitively established by rigorous field trials. If you are considering becoming pregnant or suspect that you may be, please discuss this with your provider as soon as possible so that we can discuss the risks and benefits of continuing your treatment during pregnancy.

Medical Health/Medications: Please alert us to any changes in your medical health or if you start any new medications, including over the counter medications or herbal remedies. Please also alert us to any significant change in alcohol, caffeine, or illicit substance use. Any changes in these factors can affect your seizure threshold and thus put you at higher risk for a TMS induced seizure.

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

Pacific Center for Neurostimulation

Patient Registration

Name _____ Date of Birth _____ Social Sec.#_____

Address _____City _____ State _____ Zip_____

Home phone _____ OK to leave message, including one with detailed clinical information Y/N

Work phone _____OK to leave message, including one with detailed clinical information Y/N

Cell / Pager _____OK to leave message, including one with detailed clinical information Y/N

Please list names of family members and friends we are able to leave a message with, including one with detailed clinical information:

_____

_____

_____

_____

Employer _____ Marital Status _____

Your Primary Care Physician: Name _____

Clinic_____ Phone_____

Address _____ City _____

Insurance Information:

Insurance Name and Address:_____

Member/Subscriber ID:_____ Group Number_____

Emergency contact:

1. Name _____ Phone_____

Address _____ Relationship _____

2. Name _____ Phone_____

Address _____ Relationship _____

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Pacific Center for Neurostimulation

Consent for Treatment and Statement of Financial Responsibility:

I hereby give my consent for psychiatric consultation and treatment at Pacific Center for Neurostimulation. I agree to be financially responsible for all charges that accrue from consultation and treatment. I agree to be financially responsible for cancelled appointments in accordance with the clinic's cancellation policy. I have read and received Pacific Center for Neurostimulation's attached **Office Policies**, understood its contents, and agree to the terms of treatment as stated. This authorization will remain in effect indefinitely.

Medicare acknowledgement: By initialing here, I acknowledge that all providers at Pacific Center for Neurostimulation are opted out of the Medicare provider network. If I pursue Medicare insurance I will inform my providers at Pacific Center for Neurostimulation. _____ (initial) _____ (Date)

Name Signature Date

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
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Pacific Center for Neurostimulation

Assignment of Benefits

Please fill out this form if you would like Pacific Center for Neurostimulation to bill your insurance company.

I hereby assign to Pacific Center for Neurostimulation PLLC my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance or self-insured health plan in my name or on my behalf. I further authorize payment of benefits directly to Pacific Center for Neurostimulation PLLC. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan or government plan covering services provided by Pacific Center for Neurostimulation PLLC.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Patient Signature _____Date _____

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

Pacific Center for Neurostimulation

Notice of Privacy Practices

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.

Pacific Center for Neurostimulation PLLC respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of Pacific Center for Neurostimulation PLLC. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.

- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Rebecca C. Fischer
Pacific Center for Neurostimulation
206-535-6292

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:
Rebecca C. Fischer
Pacific Center for Neurostimulation
206-535-6292

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Rebecca C. Fischer at Pacific Center for Neurostimulation 10740 Meridian Avenue North Suite 205, Seattle, Washington, 98133. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We may request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person/the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.

- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **pacificcns.com**.

7. Effective date: This Notice is effective as of February 11, 2015.

Pacific Center for Neurostimulation

Notice of Privacy Practices Acknowledgment

Pacific Center for Neurostimulation PLLC has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Pacific Center for Neurostimulation PLLC at 206-535-6292 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Pacific Center for Neurostimulation PLLC

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date Time

_____

Printed name-if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____

_____

_____

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
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Pacific Center for Neurostimulation

Deep TMS Treatment – Consent Form

Name of Physician: _____

Name of Clinic: Pacific Center for Neurostimulation

Name of Patient: _____

My doctor has recommended that I receive treatment with Brainsway Deep TMS. The nature of this treatment, including the benefits and risks that I may experience, has been fully described to me and I give my consent to be treated with Brainsway Deep TMS.
I will receive Deep TMS therapy to treat my psychiatric condition. I understand that there may be other alternative treatments for my condition. Information regarding Deep TMS is also described in the "Patient Manual" provided by my doctor, which I have had an opportunity to review.
My doctor has explained the following information to me:

I. About Brainsway Deep TMS Technology

1. Deep TMS stands for "Deep Transcranial Magnetic Stimulation." Brainsway Deep TMS is a non-invasive medical procedure. A treatment session is conducted using a device called the Brainsway Deep TMS System, which delivers pulsed magnetic fields similar in type and strength as those used in magnetic resonance imaging (MRI) machines.

2. The magnetic fields created by Brainsway's unique, patented technology allow for the targeting and stimulation of the neurons contained in the pre-frontal cortex region of the brain.

3. Brainsway Deep TMS is non-invasive, which means that no surgery or incisions into the body are needed. Deep TMS does not require the use of pharmaceutical products; therefore, patients may be able to avoid many of the physical and biological side effects often associated with drug consumption. Deep TMS also avoids the need for anesthesia, thereby eliminating certain side effects associated with Electro-Convulsive Therapy (ECT). Nevertheless, the Brainsway Deep TMS treatment is associated with certain adverse events which are detailed in the Patient Manual.

4. The FDA cleared the Brainsway Deep TMS treatment for patients suffering from Major Depressive Disorder who failed to achieve satisfactory improvement from previous anti-depressant medication treatment in the current episode. The FDA clearance was obtained following Brainsway's completion of a multicenter study in

the US and abroad which was conducted to investigate the safety and efficacy of the Deep TMS treatment.

II. The Treatment Process

1. During a treatment session, I will be comfortably seated on a chair, and a cushioned helmet will be gently placed over my head. The helmet generates brief magnetic fields, similar to those used in magnetic resonance imaging (MRI) systems. These magnetic fields briefly stimulate a targeted brain area and improve depressive symptoms.

2. During the course of the treatment, I will hear a clicking sound and feel a tapping sensation on my scalp. The operator may ask me to use standard earplugs during the treatment. The operator will then adjust the Brainsway Deep TMS system so that the device will give just enough energy to send electromagnetic pulses into the brain so that my right hand twitches. The amount of energy required to make my hand twitch is called the "motor threshold." Everyone has a different motor threshold and the treatments are given at an energy level that is just above my individual motor threshold. This threshold could fluctuate depending on a variety of factors. How often my motor threshold will be re-evaluated will be determined by my doctor.

3. Once motor threshold is determined, the helmet will be moved, and I will receive the treatment as a series of "pulses" that last about 2 seconds, with a "rest" period of about 20 seconds between each series. This treatment does not involve any anesthesia or sedation and I will remain awake and alert during the entire course of the treatment. I will likely receive these treatments daily for four weeks, and then possibly on a less frequent basis for several weeks thereafter. I will continue to be evaluated at regular intervals by the doctor during this treatment course.

4. I understand that most patients who benefit from Brainsway Deep TMS experience results by the third or fourth week of treatment. Some patients may experience results in less time while others may take longer.

5. My doctor has informed me about any applicable fees and/or insurance coverage involved in receiving Brainsway Deep TMS treatment.

III. Safety & Risk Information

1. The safety of the Brainsway Deep TMS System was demonstrated in a clinical study involving 233 patients with moderate to severe Major Depressive Disorder. However,

like other medical procedures and forms of treatment, Brainsway Deep TMS involves some risks and adverse events.

2. Seizures (sometimes called convulsions or fits) have been reported with the use of TMS devices. There was one case of seizure reported in Brainsway's FDA clinical study due to high alcohol consumption the night before, and three other cases of seizure were reported in other studies (out of approximately 50,000 treatment sessions) in cases of subjects who were on high doses of antidepressants. None of the subjects who have experienced seizure during the Deep TMS treatment have suffered lasting physical sequelae. I understand that I must discuss with my doctor if I have consumed or intend to consume alcohol/drugs prior to treatment. I understand that I must discuss with my doctor if I have a history or family history of seizure/epilepsy or potential alteration in seizure threshold. This includes stroke, head/brain injury, change in medication, change in electrolyte balance, high intracranial pressure, severe headaches or presence of other neurologic disease that may be associated with an altered seizure threshold, or concurrent medication or other drugs that are known to lower the seizure threshold, secondary conditions that may significantly alter electrolyte balance or lower seizure threshold, or where a quantifiable motor threshold cannot be accurately determined.
3. Headaches were reported in 47% of the subjects participating in the clinical study. However, 36% of patients who had received a placebo treatment instead of Deep TMS also reported headaches, indicating that the headaches reported by Deep TMS patients were not necessarily caused by the Deep TMS treatment. Headaches usually get better or go away completely with successive treatments. Additionally, headaches may be relieved by over-the-counter medicine such as acetaminophen or Ibuprofen. I understand that I should inform my doctor if this occurs.
4. Application site pain and discomfort was reported in 25% and 20%, respectively, of those subjects participating in the clinical study. I understand that I should inform the treatment administrator if I feel pain or discomfort during the treatment. The Deep TMS helmet may be slightly adjusted on the head to relieve the pain or discomfort. Pain and discomfort associated with treatment usually gets better or goes away altogether with successive treatments.
5. Other side effects which may occur include possible hearing loss, pain in jaw, muscle twitching, back pain, anxiety and insomnia. I understand that I should inform my doctor if I experience any of these adverse events.

6. If I am currently on antidepressant medications, my doctor may taper down my dosage prior to and during the course of Deep TMS treatment. Because Brainsway Deep TMS may take a few weeks before symptom improvement occurs, in the meantime my depression may worsen and increased mood instability and thoughts of suicide could occur. I understand that if I experience these symptoms, my doctor should be notified immediately.
7. I understand that Deep TMS should not be used by patients with metal implants and other metal substances in or around their heads, except for standard amalgam dental fillings. Examples of restricted metal substances include bullet fragments, stents, aneurism clips/coils, implanted stimulators, brain monitoring electrodes, ear/eye ferromagnetic implants, metal ink in facial/head tattoos and permanent makeup. I understand that failure to follow this restriction could result in serious injury or death.
8. I understand that Deep TMS should be used with caution and only upon close consultation with a doctor by patients who have implanted electronic devices (such as pacemakers, implantable cardioverter defibrillators [ICDs] or wearable cardioverter defibrillators [WCDs]) in their body. I understand that failure to follow this restriction could result in serious injury or death.
9. There were no deaths in patients who took part in the clinical trial for Brainsway Deep TMS, systematic side effects such as weight gain, dry mouth and sexual problems were not observed, and no changes to memory function were shown.

IV. Alternate Treatment Options

1. While my doctor has recommended Brainsway Deep TMS for me, I understand that a variety of other treatment options for depression exist which may be suitable for me. Which treatment option is right for me depends on a variety of factors including but not limited to previous experience, severity of my disorder, potential side effects and other factors and risks.

2. Other treatment options might include:
   - Psychotherapy
   - Medication
   - Electro-Convulsive Therapy (ECT)
   - Surface/Ordinary Transcranial Magnetic Stimulation (TMS)
   - No treatment

3. I understand that Brainsway Deep TMS is not effective for all patients with depression. I will report any signs or symptoms of worsening depression immediately to my doctor. I understand that it is advisable to have a family member or caregiver monitor any symptoms and to assist in spotting any signs of worsening depression.

Pacific Center for Neurostimulation

PATIENT VERIFICATION

I have read the information contained in this Medical Procedure Consent Form about Brainsway Deep TMS treatment, the process involved in the treatment and its potential risks. I understand there are other treatment options for my depression available to me and this has also been discussed with me. I have discussed it with my doctor who has answered all of my questions. I understand that I should feel free to ask questions about Deep TMS at any time before, during or after the course of treatment and that I may discontinue treatment at any time.

I give permission to the above named doctor, Pacific Center for Neurostimulation and the staff of Pacific Center for Neurostimulation to administer this treatment to me.

I have been given a copy of this consent form to keep.

Consent signed on _____, 20___ at _____ AM/PM

_____ _____

Signature of Patient Printed Name

_____ _____

Signature of Witness Printed Name

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

Pacific Center for Neurostimulation

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name/s: _____

I. My Authorization

Pacific Center for Neurostimulation PLLC may use or disclose the following health care information (check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition: _____
- □ Health care information in my medical record for the date(s): _____
- □ Other (e.g., X-rays, bills)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization:

Pacific Center for Neurostimulation PLLC may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose the above health care information to:

Name (or title) and organization or class of persons:

_____

Address (optional): _____ City: _____ State: ___ Zip: _____

Reason(s) for this authorization to use or disclose my health care information (check all that apply):

- □ at my request
- □ other (specify) _____

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133
phone 206.535.6292 | fax 206.356.1151

This authorization ends:

- □ on (date): _____ □ when the following event occurs: _____
- □ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - To receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Pacific Center for Neurostimulation PLLC in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from Pacific Center for Neurostimulation PLLC

   or
   - Write a letter to Pacific Center for Neurostimulation PLLC at 10740 Meridian Avenue N., Suite 205 Seattle, WA 98133.

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time