Pacific Center for Neurostimulation

Pacific Center for Neurostimulation Patient Information Packet

Thank you for your interest in our Deep Transcranial Magnetic Stimulation (dTMS) treatment program. We have provided the following information to make it easier for you to navigate your pursuit of dTMS treatment. Please review our website at www.pacificcns.com, which will answer questions related to the history, science, and efficacy of dTMS, the device we use for dTMS, as well as more detailed information related to our practice.

The following information is included in this packet:

- TMS Financial Guide (Including Insurance Coverage Information)
- Scheduling and Session Procedures
- TMS Patient Screening Form
- Referral Form
- Pacific CNS Policies and Procedures
- Release of Information
- Patient Information Form

In order to schedule a consultation, we must receive the following:

- ☐ dTMS Screening can be done one of two ways: A) Complete the dTMS Patient Screening Form (Page 4) and fax to us at 206-356-1151, or B) call 206-535-6292 to schedule a screening with one of our clinicians (schedules and times may vary).
- ☐ Your referring provider can fax the referral for (page 5), OR an intake and most recent psychiatric progress note including current and history of psychiatric medications may be faxed to us (this may require you calling your most recent provider to sign their release of information form).
    - If you are not currently seeing a psychiatric or mental health provider, and are not taking any psychiatric medications, please call our office to screen for dTMS.

Our hours are Monday-Friday from 8am – 4:30pm by appointment only. If you have any other general questions and cannot reach us by phone, please email info@pacificcns.com.

10740 Meridian Avenue N, Suite 205, Seattle, Washington 98133

phone 206.535.6292 | fax 206.356.1151

Pacific Center for Neurostimulation

dTMS Financial Guide

Thank you for considering Pacific CNS for your TMS treatment. In order to simplify the financial and insurance components related to TMS, please find the following information as a guide to assist you in assessing whether your treatment will be covered by your insurance company, and what out of pocket costs may be for you.

dTMS is a newly approved treatment, therefore, covering insurance companies are encouraging both the patient and the provider to connect to ensure you are well aware of your benefits and coverage. We know the following insurance companies cover dTMS in our region, and we are contracted providers with them: *Premera, Anthem, Labor & Industries, Uniform Medical Plan, and Regence*. However, all policies vary and most require prior authorization, are plan specific, or are not covered at 100%. Our providers are opted **OUT of the Medicare network**, therefore patients with Medicare would sign an additional form and would pay our discounted out of pocket rates.

In order to find out if dTMS is covered under your insurance policy, call the customer service number on your card, and obtain the following information:

- Request coverage for CPT codes: **90867** (TMS treatment location mapping and first session), **90868** (all TMS sessions), and **90869** (re-checking motor threshold/treatment dosage typically done about half way through your first series of TMS treatments).
- Ask whether you will need ***prior authorization*** for these codes. We will discuss this in your consultation and send in with a request for prior approval after we have established your history and feel TMS is appropriate for you. Insurances approve an initial amount of sessions based on diagnosis and medication history, as well as other factors that are different for each individual.
- Confirm whether these CPT codes would be subject to your ***deductible***, or ***coinsurance*** that has not been met, and what ***percentage*** is covered after that has been met. You would be responsible for these fees after we process payments with your insurance company.
  *Many will cover 80% before your deductible is met, and 100% after it has been met.
- In addition to your TMS sessions, you will meet with one of our Psychiatrists on a weekly basis. These sessions are billed as a regular office visit (CPT Code 99214) which may be subject to a copay, deductible, or coinsurance. These are billed as an outpatient office visit.
- Also note that some insurance companies require a primary diagnosis related to Depression, and may not approve dTMS treatment for Bipolar Disorder, or mood disorders including psychosis.

Out-of Pocket Fee's

We provide *discounted* out of pocket rates for individuals pursuing dTMS without the benefit of insurance coverage. If you know you will not be utilizing your insurance, or if we are out-of-network (OON) providers with your insurance company, please call our office for current TMS rates. For OON reimbursement, we will provide you with a statement to submit to your insurance company after each payment. Please contact your insurance company directly to learn how to submit your claims for reimbursement.

Payment Plans

We are happy to tailor a payment plan that works best for you. Please request a Payment Plan Form, and discuss these with your TMS clinician. Call us at 206-535-6292 for more information or speak with us at your initial visit.

Pacific CNS TMS Scheduling Procedures

Once you have been cleared through our screening process, you will be scheduled for a consultation with one of our three psychiatrists. Our psychiatrists are specialists in dTMS and do not see patients for medication management. However, they do consult with current or referring providers regarding medications prior to, and during your dTMS treatment series.

Standard Scheduling for first time dTMS treatment is as follows, although there may be some deviations to this protocol based on patient need. This will be discussed in your consultation session.

1. dTMS Consultation – 1.5 hours (Schedules and wait times may vary)
2. dTMS Treatment Location Mapping and Dosage incl. First TMS Session - 1-1.5 hours
3. dTMS Sessions- 30 minutes, typically prescribed for 20 daily sessions (Monday-Friday)
4. dTMS Weekly Check-In Sessions - 30 minutes (Scheduled weekly with your dTMS psychiatrist either before or after your dTMS session that day).

Maintenance of dTMS results:

Throughout your initial series of treatment, your dTMS psychiatrist and treatment team will work together to create the best plan for maintaining your dTMS results. Standard dTMS protocol recommends that patients continue 12 weeks of twice weekly sessions following your initial treatment series. Additionally, you will meet with your dTMS psychiatrist every other week.

*Treatment plans vary among all patients and this may not be what is recommended for you, but is used as a current treatment standard. If you are utilizing your insurance to cover additional sessions, we will request sessions as needed and keep you informed of these authorizations.

In addition to your dTMS treatment, our master-level therapists can create a space for talk therapy, or one of the following treatment modules:

Module 1: Behavioral Activation: Overcoming Depression One Step at a Time

Module 2: Mindfulness Based Cognitive Therapy: MBCT

Module 3: Mastery of Your Anxiety/Worry (Alt: Mastery of Anxiety/Panic)

Module 4: Dialectical Behavioral Therapy Skills

Module 5: Mindfulness Meditation/Deep Breathing

*We may also be able to accommodate earlier or later appointment times, as needed. If you have any further questions related to dTMS scheduling, please call us at 206-535-6292.

Pacific Center for Neurostimulation

Transcranial Magnetic Stimulation Adult Safety Screening Questionnaire (TASS)

Please print and complete the following form so we may review any history that may be a contraindication for you to receive dTMS treatment. Respond to each question by checking yes or no, unless otherwise indicated.

Patient Name: _____ Date: _____

1. Have you ever had an adverse reaction to TMS?	❑ YES	❑ NO
2. Have you ever had a seizure?	❑ YES	❑ NO
3. Have you ever had an EEG?	❑ YES	❑ NO
4. Have you ever had a stroke?	❑ YES	❑ NO
5. Have you ever had a head injury or loss of consciousness?	❑ YES	❑ NO
6. Do you have any metal in your head (outside of dental work) such as shrapnel, surgical clips, or fragments from welding or metal work?	❑ YES	❑ NO
7. Do you have any implanted devices such as pace makers, medical pumps, or intracardiac lines?	❑ YES	❑ NO
8. Do you suffer from frequent or severe headaches?	❑ YES	❑ NO
9. Have you ever had any other brain-related conditions?	❑ YES	❑ NO
10. Are you taking any medications? If so, which:	❑ YES	❑ NO
11. If you are a woman of childbearing age, are you sexually active, and if so, are you not using a reliable birth control method?	❑ YES	❑ NO
12. Does anyone in your family have epilepsy?	❑ YES	❑ NO
13. Do you need further explanation of TMS and its associated risks?	❑ YES	❑ NO
14. Have you recently been under intensive psychiatric care in the past 6 months (i.e. inpatient emergency care, intensive outpatient)?	❑ YES	❑ NO

Note: A positive screen is any 'Yes' answer and indicates further investigation by the clinician (but not indicating exclusion from TMS).

***Please include this in your fax to us at 206-356-1151.**

Pacific Center for Neurostimulation

REFERRAL FORM

Fax To: Pacific Center for Neurostimulation **Fax:** 206-356-1151

Date: _____

Patient Name: (First, Middle Initial, Last):
_____

Patient DOB: _____

Patient Daytime Phone:_____

Patient Evening Phone:_____

Patient Primary Insurance Carrier:_____

Brief patient history (fax additional records if indicated)**:**
_____
_____
_____
_____
_____

Medication Trials:	dose	duration	benefit
_____	_____	_____	□yes □no □partial □unsustained response □intolerable
_____	_____	_____	□yes □no □partial □unsustained response □intolerable
_____	_____	_____	□yes □no □partial □unsustained response □intolerable
_____	_____	_____	□yes □no □partial □unsustained response □intolerable

Referring Provider Name (please print):_____
Provider Clinic Facility Name:_____
Provider Telephone: _____
Provider Fax: _____
Provider Address: _____
Additional Reports To: _____

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.

Fees: An initial evaluation is $350. A follow up visit varies from $175-225 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 $400. Phone calls with our psychiatrists are $50 initially, increasing in $50 increments for every 15 minutes after the initial 15 minutes.

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.

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 page the on-call physician by calling 206-535-6292 and following the verbal instructions. 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.

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 _____

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.

Name Signature Date

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 _____

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.

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: _____

_____

_____

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) _____

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