New Year Information Sheet
Please Print All Information

Date _____ Chart #_____

Patients Name (Please Print Name):_____Male____Female: _____

Address: _____City_____Zip_____

Home Phone: _____Cell Phone: _____May we leave a message?_____

Email address: _____

Marital Status: _____ SSN # _____

Primary Care Provider:_____Phone Number:_____

In Case of Emergency, who should be notified?

Name: _____ Phone: _____Relationship:_____

Name: _____ Phone: _____Relationship:_____

Primary Insurance Company Name: _____

Name of Policy Holder: _____ Relationship to patient: _____

Date of birth of policy holder: _____Social Security number of policy holder: _____

ID Number: _____ Group Number:_____ Policy Effective Date: _____

Secondary Insurance Company Name if applicable:_____

Name of Policy Holder: _____Relationship to patient:_____

Date of birth of policy holder: _____Social Security number of policy holder: _____

ID Number: _____ Group Number: _____ Policy Effective Date:_____

Prescription Medication Card Name:_____

Name of Policy Holder: _____Relationship to patient:_____

Date of birth of policy holder: _____Social Security number of policy holder: _____

ID Number: _____ Rx Bin Number:_____Group Number: _____ Effective Date:_____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for serviced to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.
Name of Insured Signature:_____ Hereby Authorize (Name of Ins Co)_____

PLEASE READ BELOW CAREFULLY BEFORE SIGNING
To pay and hereby assign directly to Alliance Pain Center, all benefits, if any otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Alliance Pain Center., will be credited to my account, in accordance with the above said assignment. I also understand that all past due accounts are subject to finance charges. We do provide a prior authorization service as a courtesy only; however, this can be incomplete. Ultimately you are responsible for insuring authorizations with your insurance. It will be up to you as the patient to call your insurance company and find out if our providers are "IN NETWORK" with your insurance. You will be responsible for any balance that may occur from our providers not being "IN NETWORK" with your insurance. If for any reason you should be sent to collections, we will charge you 40% of the amount owed, plus an additional $50.00.

Patient or Authorized Signature: _____ Date: _____

Insurance Information

Is the pain you are experiencing from a work related injury? ☐**Yes** ☐**No** **or auto accident injury?** ☐**Yes** ☐**No**
If yes, Date of work injury _____or date of auto accident injury _____
Do you currently have an open Labor of Industries claim? ☐ Yes ☐ No or an open auto accident claim? ☐Yes ☐ No
Have you in the past had a Labor and Industries claim? ☐Yes ☐ No or past auto claim? ☐ Yes ☐ No
Please leave detail information about your L&I claim current or in the past please list who the claim is through, claim number, claim manager and phone number:

_____

_____

Please list in detail about current or past motor vehicle accident claim who the claim is through, claim number, claim manager and phone number

_____

_____

Primary Insurance Company Name: _____
Name of Policy Holder: _____ Relationship to patient: _____
Date of birth of policy holder: _____Social Security number of policy holder: _____
ID Number: _____ Group Number:_____ Policy Effective Date: _____
Secondary Insurance Company Name:_____
Name of Policy Holder: _____Relationship to patient:_____
Date of birth of policy holder: _____Social Security number of policy holder: _____
ID Number: _____ Group Number: _____ Policy Effective Date:_____
Prescription Medication Card Name:_____
Name of Policy Holder: _____Relationship to patient:_____
Date of birth of policy holder: _____Social Security number of policy holder: _____
ID Number: _____ Rx Bin Number:_____Group Number: _____ Effective Date:_____

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for serviced to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Name of Insured Signature:_____ Hereby Authorize (Name of Ins Co)_____

PATIENT FINANCIAL RESPONSIBILITY

To pay and hereby assign directly to Alliance Pain Center, all benefits, if any otherwise payable to me for their services as described on the attached form. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Alliance Pain Center., will be credited to my account, in accordance with the above said assignment. I also understand that all past due accounts are subject to finance charges. We do provide a prior authorization service as a courtesy only; however, this can be incomplete. Ultimately you are responsible for insuring authorizations with your insurance. It will be up to you as the patient to call your insurance company and find if our providers are "IN NETWORK" with your insurance. You will be responsible for any balance that may occur from our providers not being "IN NETWORK" with your insurance. If for any reason you should be sent to collections, we will charge you 40% of the amount owed, plus an additional $50.00.

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges even where Alliance Pain Center has been assigned partial benefits from government programs and insurance companies. I acknowledge failure to pay my financial obligations to Alliance Pain Center may result in the referral of my account to a professional collection agency. I consent to Alliance Pain Center to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest at the highest rate allowable under the law and attorneys' fees in the event legal action is taken.

PHONE AUTHORIZATIONS: You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such messages information required by law (including debt collection laws) and /or regarding amounts owed by you; (3) to send you text messages; (4) to use prerecorded/artificial voice messages and/or an automatic dialing device in connection with any communications made to you or related to your account.

I understand that this agreement extends to any affiliated service providers for such services provided that may bell separately from Alliance Pain Center including, but not limited to: radiology, laboratory, pathology, or any other and accept my responsibility to pay these in accordance with the payment terms set forth by those providers. I understand that I have the right to ask about costs before services are provided to me and that costs are deemed liquidated once the provider has prepared and sent the first invoice to me.

Patient Signautre_____Date_____

PAYMENT POLICY AND ELECTIONS

We accept Cash, Credit/Debit and Checks for payments.

Payments for services you receive in which you are billed for are to be paid within 30 days from the receipt of your statement. A finance fee of 12% will be added to any balance not paid within the 30 days.

Insurance:

1. We accept and bill most insurance plans. Extent of coverage may vary with each plan. Please contact your insurance company or employer regarding the extent and limitations of coverage. Any balance that may occur after the payment from insurance(s) will be the patients responsibility. This will include any balances from immunoassay and urine drug screen testing.

2. Your insurance contract requires that the CO-PAYMENT be paid in full at time of service. A charge of $15.00 dollars administrative fee will be added if we have to bill you for your co-payment.

3. State law requires insurance companies to process any single claim within sixty (60) days. If payment has not been received in sixty (60) days, you will be responsible for the amount.

4. It is the responsibility of the patient to call their insurance company and confirm that their insurance is "IN NETWORK" with our providers. It will be the patients responsibility to pay any balance that may occur because of our providers not being "IN NETWORK" with your insurance plan.

5. You are responsible for handling any delays or disputes involving your Insurance company. Our office will provide any assistance when possible. We provide a prior authorization with insurances for appointments as a courtesy only. It is ultimately up to the patient and their responsibility to check with their insurance company to insure these prior authorizations have been done prior to your appointment. If they are not, the patient is responsible for the outstanding balance that may occur.

6. It is the patient responsibility to get referrals from their primary care physician when it is required by insurance.

Patient/Guardian Signature _____ Date_____

Miscellaneous:

1. A $100.00 charge will be billed for a New Patient Appointment, cancelled without 24 hours notice . Established patients will be charged $70.00. (This fee is not covered by any insurance carrier or State agency).

2. Patients may be discharged if they have 2 or more “no show” appointments.

3. All non sufficient fund checks returned will have a $40.00 administrative fee added.

4. Alliance Pain Center uses a certain laboratory for drug screen testing. Alliance Pain Center declares, one of the providers has partial ownership in its laboratory of preference. Patients are free to choose any lab of their choice. Please contact your insurance company to be sure our lab of choice is in network with your insurance. Samples are taken at every appointment and randomly sent to the laboratory.

5.Patients could be called in for random pill counts and urine drug screen testing with any inconsistencies in urine drug screen results, aberrant behaviors, changes in medications etc. Patients will be responsible for any remaining balances.

I have read the above policy agreement and understand my responsibilities for payment of services rendered.

Patient/Guardian Signature_____ Date_____

Alliance Pain Center

Ross E. Vogelgesang, M.D
Erin Henderson, ARNP
Galina Dixon, ARNP
Kei Batangan PA-C

3240 14th Ave. NW
Olympia, WA 98502

Phone: (360) 866-7990
Fax: (360) 866-4577

Proper Disposal of Medication Education

When your medicines are no longer needed, they should be disposed of promptly. Consumers and caregivers should remove expired, unwanted, or unused medicines from their home as quickly as possible to help reduce the chance that others accidentally take or intentionally misuse the unneeded medicine, and to help reduce drugs from entering the environment.

Medicine take-back options are the preferred way to safely dispose of most types of unneeded medicines. There are generally two kinds of take-back options: periodic events and permanent collection sites. In your community, authorized permanent collection sites may be in retail pharmacies, hospital and law enforcement facilities. Our clinic offers a mail-back program to assist you in safely disposing of your unused pain medicines at a nominal fee.

If no take-back programs or DEA-registered collectors are available in your area, and there are no specific disposal instructions in the product package insert, you can also follow these simple steps to dispose of most medicines in the household trash:

- Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, cat litter, or used coffee grounds;
- Place the mixture in a container such as a sealed plastic bag;
- Throw the container in your household trash; and
- Delete all personal information on the prescription label of empty pill bottles or medicine packaging, then dispose of the container.

Some medicines come with disposal instructions. If you received disposal instructions for a medicine, you should dispose of that medicine as directed by those instructions.

DO NOT flush your medications down the toilet or sink.

For more information refer to the following resource:

https://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm

Information provided by FDA website December 20, 2018.

Chart # _____

Non-Pharmacological Treatment Modalities

State of Washington requires we collect this information and provide education regarding proper disposal of medications pursuant to new opioid prescribing rules.

Please indicate which treatments you have had for your present pain problems in the last year:

	Yes	DATE
Physical Therapy	☐	_____
Pool Therapy	☐	_____
Massage Therapy	☐	_____
TENS Unit	☐	_____
Chiropractic	☐	_____
Trigger Injections	☐	_____
Acupuncture	☐	_____
Spinal Injections	☐	_____
Facet Injections	☐	_____
Burning of the nerves	☐	_____
Spinal Stimulator	☐	_____
Intrathecal Pain Pump	☐	_____
Home Exercise	☐	_____
Surgery	☐	_____
Inpatient Rehab	☐	_____
Cognitive Behavioral Therapy	☐	_____
Kinesio Tape	☐	_____

All above N/A ☐

Other if applicable _____

_____

_____

Proper Disposal of Medication Education

By signing below I am attesting to having received the education sheet regarding Proper Disposal of Medication Education related to unused medications and all my questions were answered.

Patient Signature: _____ Date: _____

Opioid Risk Tool / 2023

Patient (please Print Name) _____ **Date** _____ **Chart #** _____

Please check each box that applies

1. Family History of Substance Abuse ☐Alcohol ☐Illegal Drugs ☐Prescription Drugs

2. Personal History of Substance Abuse ☐Alcohol ☐Illegal Drugs ☐Prescription Drugs

3. Age (mark box if between 16-45) ☐

4. History of Preadolescent Sexual Abuse ☐

5. Psychological Disease ☐Attention Deficit Disorder ☐Obsessive Compulsive Disorder ☐Bipolar ☐Schizophrenia ☐Depression