Western Washington Medical Group

**REGISTRATION FORM**

**ACCOUNT#**_____ **NEW** _____ **UPDATE** _____

| PATIENT LAST NAME | FIRST NAME (legal) | MI | PREFERRED OR NICKNAME | DATE OF BIRTH |
|---|---|---|---|---|
| | | | | |

| RACE | ETHNICITY | PREFERRED LANGUAGE | SOCIAL SECURITY # |
|---|---|---|---|
| | | | |

**SEX** M ☐ F ☐
Other: _____
(Please List)

**GENDER IDENTITY:** ☐ Genderqueer identifies as neither Male or Female
☐ Identifies as Male ☐ Female-to-male ☐ Additional gender category or other, please specify _____
☐ Identifies as Female ☐ Male-to-female ☐ Choose not to disclose

**SEXUAL ORIENTATION** ☐ Choose not to disclose
☐ Heterosexual (straight) ☐ Bisexual
☐ Homosexual (gay/lesbian) ☐ Other _____

| MAILING ADDRESS | APT # | CITY | STATE | ZIP CODE 4 DIGIT |
|---|---|---|---|---|
| | | | | |

| STREET ADDRESS | APT # | CITY | STATE | ZIP CODE 4 DIGIT |
|---|---|---|---|---|
| | | | | |

| HOME PHONE | WORK PHONE EXT | CELL PHONE | PREFERRED EMAIL ADDRESS |
|---|---|---|---|
| ( ) | ( ) | ( ) | |

**REFERRING DOCTOR**

**PRIMARY CARE DOCTOR**

**HOW DID YOU HEAR OF US?**
Internet ☐ Google Maps ☐
Friend/Family ☐
Drove by location ☐
Insurance Company ☐
Mailer/ Marketing ☐

**MARITAL STATUS**
MARRIED ☐ DIVORCED ☐ OTHER ☐
SINGLE ☐ WIDOWED ☐ SEPARATED ☐

**PHARMACY NAME, PHONE NUMBER AND LOCATION**

***PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU: RETIRED_____ OR DISABLED_____?)***

| EMPLOYER NAME | OCCUPATION |
|---|---|
| | |

| STREET ADDRESS | CITY | STATE | ZIP CODE 4 DIGIT |
|---|---|---|---|
| | | | |

***PRIMARY INSURANCE***

| INSURANCE COMPANY NAME | RELATION TO SUBSCRIBER | COPAY |
|---|---|---|
| | | |

| SUBSCRIBER'S NAME | SUBSCRIBERS EMPLOYER |
|---|---|
| | |

| SUBSCRIBERS DATE OF BIRTH | SUBSCRIBER'S SEX | SUBSCRIBERS ID # | GROUP NUMBER |
|---|---|---|---|
| | MALE ___ FEMALE ___ OTHER ___ | | |

***SECONDARY INSURANCE***

| INSURANCE COMPANY NAME | RELATION TO SUBSCRIBER | COPAY |
|---|---|---|
| | | |

| SUBSCRIBER'S NAME | SUBSCRIBERS EMPLOYER |
|---|---|
| | |

| SUBSCRIBER'S DATE OF BIRTH | SUBSCRIBERS SEX | SUBSCRIBERS ID # | GROUP NUMBER |
|---|---|---|---|
| | MALE ___ FEMALE ___ OTHER ___ | | |

**EMERGENCY CONTACT**

| ( NOT LIVING WITH YOU ) | NAME | RELATIONSHIP | PHONE NUMBER- HOME/WORK/CELL ( ) |
|---|---|---|---|
| | | | |

***RESPONSIBLE PARTY*** WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ **SELF**
(* If self do not fill in right field.)
_____ **SPOUSE**
_____ **PARENT**
_____ **GUARDIAN**

| SOCIAL SECURITY # | LAST NAME | FIRST NAME | MI |
|---|---|---|---|
| | | | |

| STREET ADDRESS | CITY | STATE | ZIP CODE 4 DIGIT |
|---|---|---|---|
| | | | |

| HOME PHONE | WORK OR CELL PHONE EXT | DATE OF BIRTH | SEX |
|---|---|---|---|
| ( ) | ( ) | | M __ F __ Other __ |

| WORKERS COMP CLAIM # | DATE OF INJURY | EMPLOYER | STATE OR SELF INSURED? |
|---|---|---|---|
| | | | |

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages by voicemail, text, email or portal, which may contain details of my medical condition.
By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.

INITIALS VOICEMAIL #

***PATIENT SIGNATURE*** ***DATE***
Type name for signature

*For office use only*

**Dr.**_____ **Ins. code**_____ **Acct #**_____ **Initials**

Western Washington
Medical Group

1728 West Marine View Drive, Suite #110, Everett, WA 98201
www.wwmedgroup.com

Patient Name: _____ DOB: _____ MRN: _____

# Financial Agreement

We consider all patients as "**private**" unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "**private**" patients is due and payable within 30 days.

Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first.

You may have scheduled a visit that is not covered by your insurance, such as Preventative Care. It is the patient's responsibility to check their benefits prior to being seen. **Please be familiar with the benefits provided by your health plan.**

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

**Co-pays are due at time of service**. If you are unable to pay your co-pay at time of service, there may be an **additional $15.00 fee** charged to your account.

Should the account be referred over to our collection agency, the undersigned, or their agent, may be responsible for payments of interest on the unpaid balance of 9% per month from the date of the service, collection fees, reasonable attorney fees, and court costs.

We charge **$35.00** for any NSF checks (per RCW 62A-3-515 & 520).

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

**No show/Late Cancellation Fee:** All WWMG clinics require a minimum 24-hour notice of any appointment cancellations or reschedules, including telehealth appointments. Fees may vary by clinic, please contact your provider's office for details. Late cancellation/no-show appointments will be charged:

- $50 for Primary Care and Imaging Center appointments/office visits
- $50 for Podiatry care center appointments/office visits
- $100 for Specialty care center appointments/office visits
- $150 for Psychology care center appointments/office visits
- $250 for surgeries, Endoscopy Center procedures, and in-office procedures

After 3 no-show appointments and/or late cancellations (with less than a full 24 hour notice to our clinics), you will be asked to leave the practice. Missed appointments take up valuable time that could be offered to another patient.

**I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.**

Printed Name _____ DOB _____

Signature _____ Date _____

Western Washington Medical Group

WWMG
1728 W Marine View Drive #110, Everett, WA 98201
(425) 259-4041 Fax: (425) 252-6642

# Registration Form Packet

Name: _____ DOB: _____ MRN: _____

## Consent to Release Information to Friends and Family

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)* **WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:**

☐ HIV (Aids virus)
☐ Sexually Transmitted Infections (STIs)
☐ Psychiatric disorders / Mental health
☐ Alcohol / Substance abuse
☐ All other health information
Other: _____

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

*Name* _____ *Relationship* _____ *Phone* _____

*Name* _____ *Relationship* _____ *Phone* _____

*Name* _____ *Relationship* _____ *Phone* _____

**<u>Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.</u>**
Please provide us with **YOUR best, most** current phone contact information. This information will become part of your permanent medical record *<u>unless/until you change it.</u>* You can change this information simply by asking to complete a new form.
**Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.**

| **First phone number** | **Second phone number** | **Third phone number** |
|---|---|---|
| Check one: Cell Work Home<br>OK to leave detailed message?: Y N | Check one:Cell Work Home<br>OK to leave detailed message?: Y N | Check one:Cell Work Home<br>OK to leave detailed message?: Y N |

_____ _____
*Signature of client (or personal representative)* *Date*

**If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:**

_____ _____
*Personal Representative's Name* *Relationship to Client*

Western Washington Medical Group

WWMG
1728 W Marine View Drive #110, Everett, WA 98201
(425) 259-4041 Fax: (425) 252-6642

Registration Form Packet

Name: _____ DOB: _____ MRN: _____

# Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____

*Signature of client (or personal representative)* *Date*

**If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:**

_____ _____

*Personal Representative's Name* *Relationship to Client*

---

**For Office Use Only**

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
Other: _____

_____ _____

*Employee Name* *Date*

This form will be retained in your medical record

Western Washington Medical Group

PLACE LABEL HERE

**Spine / Initial Eval***

## Present History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ Other (specify below)
- ☐ Fall
- ☐ Bending
- ☐ Pulling
- ☐ Injured at work
- ☐ Injured in auto accident
- ☐ Hit from behind
- ☐ Injured during sports
- ☐ No apparent cause
- ☐ Injured at home

If other, please specify _____

Do you have any emotional reactions to your current problem? ○ Yes ○ No

If yes, what are the emotional reactions you have related to your current problem?

- ☐ I feel nothing matters
- ☐ I feel frustrated
- ☐ I feel angry
- ☐ I feel like taking my own life (suicidal)
- ☐ I feel sad (depressed)
- ☐ Nothing can help me

## Pain

**My pain is**

- ☐ Present Intermittently
- ☐ Present but varies in intensity
- ☐ Improving
- ☐ Worse -present more often
- ☐ Worse - more intense
- ☐ Worse - changing in character
- ☐ Worse - changing in location

Please mark the severity of pain that corresponds to the area of your body. Rate how much pain hurts on an average day.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Back pain** | ○ 0 none | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 worst |
| **Leg pain** | ○ 0 none | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 worst |
| **Neck pain** | ○ 0 none | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 worst |
| **Arm pain** | ○ 0 none | ○ 1 | ○ 2 | ○ 3 | ○ 4 | ○ 5 | ○ 6 | ○ 7 | ○ 8 | ○ 9 | ○ 10 worst |

## Past Treatments for this Problem

Have you had any troubles with this problem before? ○ Yes ○ No

If yes, when was the FIRST time it happened: ___/___/___

Have you seen any other doctors for your current problem? ○ Yes ○ No

If yes, list their name and date seen _____

Which of the following treatments have you had for this problem?

- ○ Physical therapy
- ○ Home exercise program
- ○ Brace
- ○ TENS Unit
- ○ Epidural Steroid Injection
- ○ Chiropractic Manipulation
- ○ N/A - no prior treatments

If you answered yes to any of the post treatments listed above, please provide additional details below. If you have not had any prior treatments for this problem please continue to the next section.

Physical Therapy ___/___/___ Where? _____ # of Sessions: _____

if physical therapy, what was done and was it helpful? _____

Exercise ___/___/___

Are you currently doing home exercises? ○ Yes ○ No

Brace ___/___/___

If yes, what type of brace?

TENS Unit ___/___/___

Are you currently using a TENS unit? ○ Yes ○ No

Epidural Steroid Injection ___/___/___

Was it helpful and how long did it last? _____

Epidural Steroid Injection #2 ___/___/___

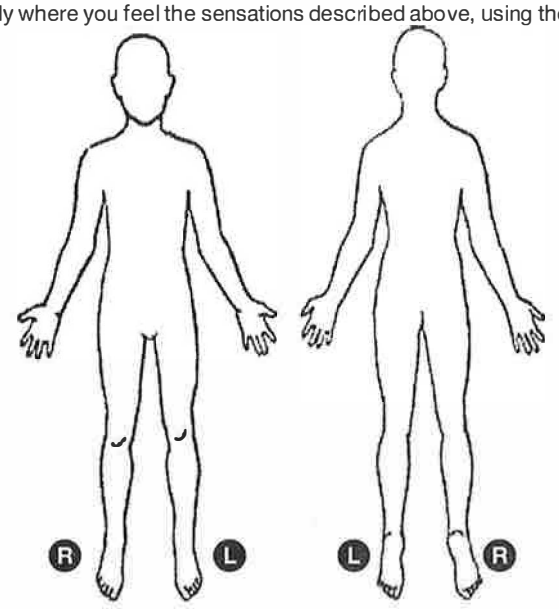
Was it helpful and how long did it last? _____

Epidural Steroid Injection #3 ___/___/___

Was it helpful and how long did it last? _____

Please continue to the next page...

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads.




✔ Stabbing
● Tingling
– Numbness
+ Pins and Needles
▲ Aching
× Burning

Do you have loss of bowel or bladder control? ○ Yes ○ No

My weight Is ○ Increasing ○ Decreasing ○ Steady

Are there any problems with weak muscles? ☐ None ☐ Weak in arms ☐ Weak in legs ☐ Generally weak

Sleep pattern ☐ No difficulty with sleep ☐ Unable to fall asleep ☐ Can't maintain sleep ☐ Wake frequently due to pain

## Functional Activities

I can comfortably sit for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

I can comfortably stand for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

I can comfortably walk for ○ 1 min ○ 5 min ○ 10 min ○ 15 min ○ 20 min ○ 30 min ○ 45 min ○ 1 hour ○ 2 hours +

## Daily Activities

I can do_____ of my housework ○ All ○ Some ○ None

I can do_____ of my leisure activities ○ All ○ Some ○ None

I can do_____ of my work ○ All ○ Some ○ None

My sex life is
○ normal with no pain
○ normal with some pain
○ nearly normal, but painful
○ severely restricted by pain
○ nearly absent because of pain
○ absent, pain prevents any sex

Do you have any difficulty with sexual function? ○ Yes ○ No ○ N/A

## Prior Tests

What tests have you had done for your problem? ☐ X-ray ☐ Myelogram ☐ CT ☐ Bone scan ☐ MRI ☐ EMG ☐ Discogram ☐ N/A

If you have had any of the tests listed above, please provide additional details if you know them.

X-ray ____/____/____ Where? _____ Results _____

Myelogram ____/____/____ Where? _____ Results _____

CT ____/____/____ Where? _____ Results _____

Bone Scan ____/____/____ Where? _____ Results _____

MRI ____/____/____ Where? _____ Results _____

EMG ____/____/____ Where? _____ Results _____

Where? Results

Western Washington Medical Group

# Medical History*

| **Current Medications**, inhalers, eye drops, patches... | **Dose and Frequency** | **What do you take it for?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Supplements, Herbal remedies**, currently taking | **Dose and Frequency** | **What do you take it for?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| **Allergies** | **Reaction that you had** |
|---|---|
| ☐ Latex | |
| ☐ Iodine | |
| ☐ Penicillin | |
| ☐ Sulfa | |
| Other | |
| Other | |
| Other | |
| ☐ Food Allergies: | |

| **Serious injuries or fractures** | |
|---|---|
| | |
| | |
| **Serious injuries or fractures** | |
| | |
| | |
| | |

**Review of Systems (check all that apply)**

| | | | | |
|---|---|---|---|---|
| Constitutional | ☐ Fever ☐ Chills | ☐ Sweats ☐ Fatigue | ☐ Recent weight loss | ☐ No complaints |
| If recent weight loss, how many pounds lost? | | | | |
| Skin | ☐ Rashes | ☐ Sores | ☐ Scars | ☐ No complaints |
| Cardiovascular | ☐ Chest Pain | ☐ Palpitations | ☐ Swelling hands/feet/ankles | ☐ No complaints |
| Respiratory | ☐ Short of breath | ☐ Cough | ☐ Coughing blood | ☐ No complaints |
| Hematologic | ☐ Bruise easily | ☐ Bleeding disorder | ☐ Blood clots | ☐ No complaints |
| Stomach/Intestinal | ☐ Heartburn | ☐ Constipation | ☐ Abdominal pain | ☐ No complaints |
| Urology | ☐ Pain with urination | ☐ Incontinence | ☐ Frequent urination | ☐ No complaints |
| Musculoskeletal | ☐ Stiffness | ☐ Sprains | ☐ Swelling | ☐ No complaints |
| Neurological | ☐ Headaches | ☐ Numbness | ☐ Dizziness | ☐ No complaints |
| Mental Health | ☐ Anxiety | ☐ Depression | ☐ Sleep problems | ☐ No complaints |

This form was completed by ○ Patient ○ Parent/Guardian

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record at Western Washington Medical Group.

X _____ DATE _____

Patient Name_____ Today's Date_____

## REVIEW OF SYSTEMS

*Have you had any of the following during the past year?*
*Please circle Yes if any apply to you*

**Cardiac**
Chest pain ..... Yes
Swelling in legs/ Edema ..... Yes
Leg cramps or calf pain ..... Yes
Palpitations or arrhythmias ..... Yes

**Constitutional/ General**
Fevers ..... Yes
Headaches ..... Yes
Sleeping difficulty ..... Yes
Fainting ..... Yes

**Eyes**
Double or blurry vision ..... Yes
Wear Glasses or contacts ..... Yes
Eye disease or injury ..... Yes

**Gastrointestinal**
Blood in stool ..... Yes
Diarrhea ..... Yes
Constipation ..... Yes
Nausea or vomiting ..... Yes
Acid indigestion/ heartburn ..... Yes

**Genitourinary**
Blood in urine ..... Yes
Frequency in urination ..... Yes
Burning or painful urination ..... Yes
Incontinence or dribbling ..... Yes

**Hematology**
Bruises or bleeds easily..... Yes
Bleeding disorder..... Yes
Blood clot, DVT, or a Yes
Pulmonary embolism... Yes

**Pulmonary**
Shortness of breath ..... Yes
Wheezing ..... Yes
Asthma..... Yes
Frequent cough ..... Yes
COPD or Emphysema..... Yes

**Skin**
Rashes or itching..... Yes
Changes in moles or skin lesions Yes
Psoriasis..... Yes

**Musculoskeletal**
Limping..... Yes
Joint pain..... Yes
Joint stiffness..... Yes
Joint swelling..... Yes
Numbness to arm or leg..... Yes

***Patient's Signature:*** _____
(or parent/legal guardian)

Practitioner's Initials_____

## PAST MEDICAL HISTORY

*Have you ever had any of the following?*
*Please circle Yes if any apply to you*

Yes Diabetes
Yes Thyroid disorder
Yes Kidney or Renal disorder
Yes Stroke/TIA
Yes Seizures or Epilepsy

Yes Anemia
Yes Varicose Veins
Yes High Blood Pressure
Yes High Cholesterol
Yes Heart Problems _____

Yes Heart Attack/ Myocardial Infarction
Yes Heart Stents or Balloon Angioplasty
Yes Atrial Fibrillation
Yes Irregular Heartbeat

Yes Pacemaker
Yes Heartburn, Acid reflux
Yes Ulcers or Gastritis
Yes Esophagitis, Barrett's or Hiatal Hernia
Yes Seasonal Allergies
Yes Sleep Apnea, if Yes CPAP use? _____

Yes Tuberculosis
Yes Gout
Yes Cancer _____
Yes Migraines
Yes Depression

Yes Anxiety
Yes Fibromyalgia
Yes Chronic Pain _____
Yes Hepatitis A , B , C (circle which)
Yes HIV or exposure to it

Yes History of MRSA, VRE, Staph infections

Yes Anesthesia problems? _____
Yes Post Operative Nausea/Vomiting

**Other Diagnoses or Symptoms that we should be aware of?**

_____

_____

_____

Western Washington Medical Group

# Medical History*

## Surgery

Have you had surgeries for this problem? ○ Yes ○ No

If yes, please list surgeon, if it was helpful and what was done.

Have you had breast implants? (necessary for surgeries that require you to lie on your stomach) ○ Yes ○ No ○ N/A

Would you accept blood products or blood transfusion if necessary? ○ Yes ○ No

Have you ever had complications with surgery? ○ Yes ○ No

If so, please list the name of the surgery and any complications below. You may wish to include problems before, during, or after your procedure, as well as any problems you may have had with anesthesia.

Complication _____ Year _____

Complication _____ Year _____

## Employment Status

Are you currently employed? ○ Yes ○ No Present employer _____

What is your occupation? _____ How long have you worked there? _____

My present job consists of: ☐ Ladders ☐ Lifting ☐ Sitting ☐ Standing ☐ Stairs ☐ Walking

Other Job Duties _____

Per work day, how many hours do you sit? ○ <1 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ >8

Per work day, how many hours do you stand? ○ <1 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ >8

How many pounds do you lift for your job? ○ <15 lbs ○ 15-25 lbs ○ 25-40 lbs ○ 40-60 lbs ○ >60 lbs

If unemployed or currently not working, please provide a date for at least one of the following.

Retired on ___/___/___ Total disability ___/___/___

Medical leave began ___/___/___ Social Security disability ___/___/___

Laid off ___/___/___ When did you last work? ___/___/___

Would your employer allow you to return to work with restrictions? ○ Yes ○ No

## Social History

What sports, exercise activity, or hobbies do you participate in? _____

Do you live alone or as only adult in the house? ○ Yes ○ No

Alcohol use: Never Rarely Moderate Daily # of drinks ____ Recovery Treatment

Tobacco use: Never Yes, current packs/day_____ How many years _____ Quit-year ____

This form was completed by ○ Patient ○ Parent ○ Guardian ○ POA ○ Family member ○ Other

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record.

X _____ DATE _____

## Pain Catastrophizing Scale

Everyone experiences painful situations at some point in their lives. We are interested in the types of thoughts and feeling that you have when you are in pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

| | Not at all | To a slight degree | To a moderate degree | To a great degree | All the time |
|---|---|---|---|---|---|
| I worry all the time about whether the pain will end | 0 | 1 | 2 | 3 | 4 |
| I feel I can't go on | 0 | 1 | 2 | 3 | 4 |
| It's terrible and I think it's never going to get any better | 0 | 1 | 2 | 3 | 4 |
| It's awful and I feel that it overwhelms me | 0 | 1 | 2 | 3 | 4 |
| I feel I can't stand it anymore | 0 | 1 | 2 | 3 | 4 |
| I become afraid that the pain will get worse | 0 | 1 | 2 | 3 | 4 |
| I keep thinking of other painful events | 0 | 1 | 2 | 3 | 4 |
| I anxiously want the pain to go away | 0 | 1 | 2 | 3 | 4 |
| I can't seem to keep it out of my mind | 0 | 1 | 2 | 3 | 4 |
| I keep thinking about how much it hurts | 0 | 1 | 2 | 3 | 4 |
| I keep thinking about how badly I want the pain to stop | 0 | 1 | 2 | 3 | 4 |
| There's nothing I can do to reduce the intensity of the pain | 0 | 1 | 2 | 3 | 4 |
| I wonder whether something serious may happen | 0 | 1 | 2 | 3 | 4 |

## Neuropathic Pain Questionnaire

1 Numbness: rate your usual pain:

**0** ← → **100**

No Numbness/Sensation — Worst Numbness Imaginable

2 Tingling Pain: rate your usual pain:

**0** ← → **100**

No Tingling/Pain — Worst Tingling Pain Imaginable

3 Increased Pain Due To Touch: rate your usual pain:

**0** ← → **100**

No Increase At All — Greatest Increase Imaginable

Patient Name:_____ Date:_____

# Opioid Assessment for Patients

| | | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 |
| 1 | How often do you have mood swings? | O | O | O | O | O |
| 2 | How often have you felt the need for higher doses of medication to treat you pain? | O | O | O | O | O |
| 3 | How often have you felt impatient with your doctors? | O | O | O | O | O |
| 4 | How often have you felt that things are just too overwhelming that you can't handle them? | O | O | O | O | O |
| 5 | How often is there tension in the home? | O | O | O | O | O |
| 6 | How often have you counted pain pills to see how many are remaining? | O | O | O | O | O |
| 7 | How often have you been concerned that people will judge you for taking pain medication? | O | O | O | O | O |
| 8 | How often do you feel bored? | O | O | O | O | O |
| 9 | How often have you taken more pain medication than you were supposed to? | O | O | O | O | O |
| 10 | How often have you worried about being left alone? | O | O | O | O | O |
| 11 | How often have you felt a craving for medication? | O | O | O | O | O |
| 12 | How often have others expressed concern over your use of medication? | O | O | O | O | O |
| 13 | How often have any of your close friends had a problem with alcohol or drugs? | O | O | O | O | O |
| 14 | How often have others told you that you had a bad temper? | O | O | O | O | O |
| 15 | How often have you felt consumed by the need to get pain medication? | O | O | O | O | O |
| 16 | How often have you run out of pain medication early? | O | O | O | O | O |
| 17 | How often have others kept you from getting what you deserve? | O | O | O | O | O |
| 18 | How often, in your lifetime, have you had legal problems or been arrested? | O | O | O | O | O |
| 19 | How often have you attended an AA or NA meeting? | O | O | O | O | O |
| 20 | How often have you been in an argument that was so out of control that someone got hurt? | O | O | O | O | O |
| 21 | How often have you been sexually abused? | O | O | O | O | O |
| 22 | How often have others suggested that you have a drug or alcohol problem? | O | O | O | O | O |
| 23 | How often have you had to borrow pain medications from your family or friends? | O | O | O | O | O |
| 24 | How often have you been treated for an alcohol or drug problem? | O | O | O | O | O |

Please include any additional information you wish about the above answers. Thank you

Patient Name:_____ Date:_____

Western Washington Medical Group

# Your Information. Your Rights. Our Responsibilities.

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.**

## Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

## Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you:

**Get an electronic or paper copy of your medical record**

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**
- You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**
- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

## Your Choices
**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care or payment for your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

## Our Uses and Disclosures

## How do we typically use or share your health information?
We typically use or share your health information in the following ways:

**Treat you**

We can use your health information and share it with other professionals who are treating you.
*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

**Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
*Example: We give information about you to your health insurance plan so it will pay for your services.*

## How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

## Other Instructions/ Information Related for Notice

- Effective Date of this Notice: 08/06/2026

- Melissa Danielson, Compliance Officer (425) 259-4041.

- **Marketing Communications; Sale of PHI**.
  We must also obtain your written authorization prior to using or disclosing PHI for marketing purposes or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

- **Psychotherapy Notes**:
  We must also obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes; (2) for our own training programs in which mental health students, trainees or

practitioners learn under supervision to practice or improve their counseling skills; (3) to defend ourselves in a legal proceeding initiated by you; (4) as required by law; (5) by a health oversight agency with respect to the oversight of the originator of the psychotherapy notes; (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

- **Uses and Disclosures of Your Highly Confidential Information**:
  In addition, federal and state law requires special privacy protections for certain highly confidential information about you, including the subset of your PHI that: (1) is about mental health and developmental disabilities services; (2) is about alcohol and drug abuse prevention, treatment and referral; (3) is about HIV/AIDS testing, diagnosis or treatment; (4) is about venereal disease(s); (5) is about genetic testing; (6) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

- **Use of PHI for Research**:
  For Research. Medical research is vital to the advancement of medical science. Federal regulations permit use of protected health information in medical research. Our clinical researchers may look at your health records as part of your current care, or to prepare, or conduct research. All patient research conducted at Western Washington Medical Group is reviewed and approved by an Institutional Review Board before any medical research study begins. You may opt out of being contacted to participate in clinical research by contacting the Privacy Officer at (425) 259-4041.

- **Use of PHI for Operations**:
  We may use technologies, including artificial intelligence tools, to assist our clinicians with documentation and care delivery. These tools are subject to appropriate privacy and security protections. You may request alternative documentation approaches where available.

- **Use of PHI with Business Associates**:
  We may share your information with business associates who perform services on our behalf, who are required to protect your information.

- **De-Identified Information**: We may use your health information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law without your authorization or consent, including but not limited to, research studies, use or development of artificial intelligence tools and other advanced technologies, and health care/health operations improvement activities.

- We provide our patients with access to their health information using an **online portal**.

- **SMS Communications and Mobile Information:**
  Western Washington Medical Group ("WWMG") may collect mobile telephone numbers, SMS communication preferences, opt-in consent, opt-out requests, message interactions, and related information when individuals enroll in or use the WWMG text messaging program.
  WWMG uses this information to send non-marketing communications regarding appointment reminders, appointment confirmations, scheduling, cancellation or rescheduling, patient onboarding, care-related administrative notifications, billing, account updates, and customer support.
  Mobile information, including mobile telephone numbers and SMS opt-in consent, will not be sold, rented, or shared with third parties or affiliates for marketing or promotional purposes.
  WWMG may disclose mobile information to service providers and business associates that assist WWMG in operating and delivering the text messaging program. Information is disclosed only as necessary to provide those services and remains subject to applicable contractual, privacy, and security requirements.
  Message frequency varies. Message and data rates may apply. Reply STOP to any WWMG text message to opt out or reply HELP for assistance.
  Opting out of SMS messages does not affect the ability to receive medical treatment or services from WWMG. Communications may continue through other channels based on the patient's communication preferences and as permitted by law.