CARLA HELLEKSON, MD, PLLC

PSYCHIATRY & SLEEP MEDICINE
1300 - 114th Avenue S.E., Suite 102, Bellevue, WA 98004
www.drhellekson.com
Phone 425-688-1888
Fax: 425-696-0083

Welcome to my practice of Psychiatry and Behavioral Sleep Medicine. I look forward to meeting with you. Please read each of the items listed below and fill out all forms, to the best of your ability, ***black ink****. Bring a copy with you to our first session.*

NEW PATIENT ENROLLMENT

Enclosed please find the following items for you to review and complete:

- ☐ New Patient Registration and Acknowledgment of Receipt of Notice of Privacy Practices & Policies, Receipt of Notice of Office Policies & Procedures

- ☐ Insurance Information and Help Sheet: "Checking your outpatient mental health insurance benefits"
  Billing and patient accounts are administered by *Northwest Clinical Billing*
  Phone: 800-831-3322
  Fax: 360-491-8007
  Email: david@nwclinical.com

- ☐ Authorization of assignment of benefits to release information for treatment, billing, or healthcare operations*
  **Authorization is not required for treatment. However, it may be required for sending your insurance company additional information requested for claims processing.*

- ☐ Authorization to exchange patient health information with other providers, if indicated

- ☐ Notice of Office Policies & Procedures for Carla Hellekson, M.D., P.L.L.C. (for your records)

- ☐ Notice of Privacy Practices & Policies for Carla Hellekson, M.D., P.L.L.C. (for your records)

Thank you for your kind consideration. I look forward to meeting you in the near future.

Carla Hellekson, MD, PLLC

(VISION IMPAIRED? REQUEST FORMS IN LARGER FONT)

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NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: _____ **DOB:** _____ **Sex:** _____
Mailing Address: _____
City, State, Zip: _____
SSN: _____ **Employer:** _____ _____
Home Phone: _____ **Work Phone:** _____ _____
Cellular Phone: _____
Best message phone ? **Home D** **Cellular D**
Work Email: _____
May we send a message? **Yes D** **No D**
Home Email: _____ _____
May we send a message? **Yes D** **No D**

MEDICAL AND REFERRAL INFORMATION

Name of Primary Care Provider:
Telephone Number:_____ **Fax Number:** _____
Name of Pharmacy: _____
Pharmacy Telephone: _____ **Pharmacy Fax Number:** _____
Who referred you to our practice? _____

EMERGENCY CONTACT

Who should we contact in case of an emergency? _____
Relationship to you: _____**Best contact phone:** _____

Acknowledgment of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notice of Office Policies and Procedures

I have received a copy of the Notice of Privacy Practices and Policies, and received a copy of the Notice of Office Policies and Procedures, from Carla Hellekson, MD, PLLC. I understand the cancellation policy.

Patient Signature: _____

Date: _____
If signed by patient's representative, explain relationship.

HEALTH INSURANCE INFORMATION

In order for any claims to be submitted to your health insurance company, the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).Questions? Call ***NW Clinical Billing 1-800-831-3322, or email david@nwclinical.com****. Also, see Form "Checking your Insurance Benefits" for questions to ask when you call your insurance provider.*

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Patient ID: _____ Patient Birth Date: _____

Subscriber on Policy:

Subscriber ID: _____ Subscriber Birth Date:

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

***THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Patient ID: _____ Patient Birth Date: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

ASSIGNMENT OF BENEFITS

I hereby assign to *Carla Hellekson, MD, PLLC* my right to the insurance benefits that may be payable to me for the services provided, in my name or in my behalf. I further authorize those payments be made directly to *Carla Hellekson, MD, PLLC*. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services. The doctor may release all or part of my medical record to the insurance company required for processing any claims. The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.

Patient Signature _____Date _____

If signed by patient's representative, specify relationship

CHECKING YOUR OUTPATIENT MENTAL HEALTH INSURANCE BENEFITS

Please contact NW Clinical Billing 1-800-831-3322 *before your 1st visit. Health insurance plans vary in the kinds of outpatient mental health services they cover. Here are some important questions to understand about your coverage when checking on your benefits and eligibility,*

Telephone number to call to check my benefits and eligibility: _____

Does my insurance cover *outpatient mental health* services? ……. Yes ☐ No ☐

Is my health insurance coverage *active*? …… Yes ☐ No ☐

If yes, my policy became effective on: _____

Are my mental health benefits based on a calendar year? ……... Yes ☐ No ☐

If not, my benefits are based on this range of dates: _____

How many outpatient mental health *visits* are covered for one (1) year? _____

How many *remaining visits* do I have for the current year? _____

Is Dr. Hellekson a "*preferred*" or "*in-network provider*" for my health insurance plan? (Please be sure to specify the practice address.) …….. Yes ☐ No ☐

<u>For Dr. Hellekson's services:</u>

Do I pay a *co-pay* for each visit? ……... Yes ☐ No ☐

If yes, my co-pay amount for each visit is: _____

Do I have a *co-insurance* cost for each visit (a percentage of the charge that I have to pay myself)? ……. Yes ☐ No ☐

If yes, my co-insurance percentage for each visit is: _____

Do I have to obtain an *authorization* for Dr. Hellekson's services? ……. Yes ☐ No ☐

If yes, who must call? …….. My referring provider ☐ Myself ☐ Dr. Hellekson ☐

The number to contact to obtain an authorization is: _____

Before the 1st appointment, you should understand the above information. Please be sure to bring this form with you to your first appointment. Thank you.

Patient Name: _____ **Date:** _____

CARLA *HELLEKSON, MD, PLLC*

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NOTICE OF OFFICE POLICIES AND PROCEDURES, effective May 14, 2015

PURPOSE OF THIS INFORMATION

In order for me to provide the best care possible, I want my patients to have as much pertinent information as possible. If you have any questions or concerns about the healthcare or business practices of this office, please feel free to discuss them with me.

EMERGENCY CONTACT

If you are experiencing a medical emergency and /or need rapid attention for your own or someone else's safety, please dial 911. For the Crisis Line, dial (206) 461-3222, or (866) 427-4747.

Messages left on voice mail at (425) 688-1888 # 2, will be returned within the next business day, Mondays through Thursdays. For Urgent matters, Mondays through Thursdays until 5 pm, mark the message urgent, and it will be forwarded to my mobile phone. For Urgent matters from Thursdays 5 pm to Mondays 8 AM, listen to the Voice Mail which indicates which psychiatrist is on call for Urgent matters for the weekend, and call them. Do not delay care for an Emergency, by waiting for a return call, dial 911, or report to the nearest hospital emergency room.

LATE CANCELLATIONS AND MISSED APPOINTMENTS

Cancellations must be received 24 hours in advance, by the previous business day (by Friday noon, for a Monday appointment). Failure to keep a scheduled appointment will result in a charge for the full fee of the scheduled appointment. Exceptions to this include emergencies outside of your control (i.e. death of a loved one). Please note that insurance health plans do not pay for missed appointments; these charges will be entirely your responsibility.

PATIENT RECORDS

An electronic record (file) is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to entities you designate, at your expense, according to charges stipulated by Washington State law. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record. You may receive a free copy of your record and a free accounting of non-routine disclosure(s) each year, by contacting C. Hellekson, MD, PLLC.

SECURITY PROCEDURES

I make reasonable efforts to prevent efforts to prevent access and disclosure to unauthorized personnel. I keep an ongoing log of potential risks and the physical and electronic safeguards implemented to limit these risks. I require my business associates to abide by all applicable Privacy regulations.

PRIVACY AND RELEASE OF INFORMATION

See attached Notice of Privacy Practices for important details about your record's privacy.

INSURANCE BENEFITS AND PATIENT RESPONSIBILITY FOR FEES

I participate with certain, but not all, of the Regence, & Premera health insurance plans, but will work with other insurance companies as an out-of-network provider. I have "opted out" of Medicare, and do not participate in Cigna, United Health Care, Aetna, or Value Options. Only your health insurance plan can describe your benefits to you or verify provider eligibility. **NW CLINICAL BILLING, 1-800-831-3322** will help you obtain this information from your health insurance plan, but you are ultimately responsible for the understanding your health insurance plan benefits. If charges are denied by a health insurance plan, they become entirely your responsibility, even if you had understood from your health insurance plan that the charges would be paid by them.

FEES AND PAYMENT

Payment for charges not covered by your health insurance plan (including co-payment and deductible amounts) is due in full at the time services are provided, unless prior arrangements have been made. My billing and patient accounts are administered by **NW Clinical Billing, 1-800-831-3322.** Please call them directly with any questions about your account.

UNPAID BILLS

It is important that you discuss with me any financial hardship that you may have. Doing so may allow us to arrive at a mutually agreeable payment plan that allows the continuation of your treatment. If this cannot be accomplished, seriously delinquent accounts may be referred to a collection agency and we may have to terminate our relationship as provider and patient. Information necessary to effect collection will be released to the collection agent. Should it become necessary to file a suit in this context, you agree to pay reasonable attorneys fees. A service fee of 1.5 % will be charged on balances more than ninety (90) days past due based on date of service.

FEES

Fees as of May 1, 2015 are based on the length and complexity of the visit. Initial evaluation and report are $350 and follow up visits range from $150, $200, or more, depending on length and complexity. These fees are subject to change, and any changes will be discussed with you. Fees for other services are by arrangement.

GRIEVANCE PROCEDURES AND COMPLAINTS

If you have any questions or concerns about your treatment, you are encouraged to discuss them with me. In addition, or instead, the following avenues are available:

1. You may contact your health insurance plan or behavioral health benefit manager.
2. If you feel that problem is serious and/or you have not reached resolution through one of the avenues above, you can file a complaint with the Washington State Department of Health. Their mailing address is Post Office Box 47857, Olympia, WA 98504-7857 and their telephone number is (360) 236-4700.
3. Complaints re: privacy practice to the Secretary, U.S. Dept. Health & Human Services

Carla Hellekson MD PLLC : NOTICE OF PRIVACY PRACTICES AND POLICIES, *EFFECTIVE October 1, 2007*

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by *Carla Hellekson, M.D.,PLLC* whether created by me, my personnel or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information (PHI) (information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the following categories.

A. DISCLOSURES WHICH REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or healthcare operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents and business associates of the practice. The definition of health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. Therefore, if you would like information submitted to one of these companies, an authorization will be required, unless I am otherwise required by state or federal law.

B. ROUTINE SITUATIONS

1. **For Treatment** I may use information about you to provide you with medical treatment or services. Treatment is when I provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when I consult with another healthcare provider, such as your primary care physician.
2. **For Payment** I may use and disclose information about you so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company, or a third party (including a collection agency if necessary). For example, I may give your health insurance plan information about services you received at the practice so your health insurance plan will pay my practice or reimburse you for the services. I may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.
3. **For Healthcare Operations** I may use and share information about you for administrative functions necessary to run my practice and promote quality care. I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services. I will contractually bind these third parties to protect your information as I would. Also, I may permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.
4. **Communicating with You and Others Involved in Your Care** My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

C. SPECIAL SITUATIONS

1. **As Required By Law:** I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid court subpoena.
2. **Health Oversight Activities**: I may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
3. **For Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that you have received within my practice and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena requiring provision of such information of which you have been properly notified and in response to which you have not opposed the court subpoena within the legally specified format and timeframe, or in the instance of the issuance of a court order compelling me to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
4. **To Avert Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I believe reasonably that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threat of harming another individual may be reported to appropriate authorities.
5. **Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make available, at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.
6. **Public Health Risks:** I may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:
    a. To prevent or control disease, injury, or disability
    b. To report child abuse or neglect
    c. To report adult and domestic abuse
    d. To report reactions to medications or problems with products
    e. To notify people of recalls of products they may be using
    f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
7. **Law Enforcement**: I may release information about you if asked to do so by a law enforcement official:
    a. In response to a court order, subpoena, warrant, summons, or similar process
    b. To identify or locate a suspect, fugitive, material witness, or missing person
    c. If you are suspected to be a victim of a crime, generally with your permission
    d. About a death we believe may be the result of criminal conduct
    e. About criminal conduct at the hospital
    f. In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

YOUR RIGHTS AS A PATIENT

In addition to provisions by the practice to protect your confidential information, you are entitled to six (6) specific rights as a patient.

1. **You have the right to request restrictions on certain uses and disclosures.** You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing to me. In your request, you must tell me: (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want it to apply. I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.
2. **You have the right to receive confidential communications.** You have the right request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing to me. Your request must specify how or where you wish to be contacted. I will not ask you the reason for your request. I will seek to accommodate all reasonable requests.
3. **You have the right to inspect and obtain copies.** You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding; and confidential information related to certain laboratory tests under Clinical Laboratory Improvement Amendments (CLIA). To inspect and copy information that may be used to make decisions about you, you must submit your request to me in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances I may deny your request to inspect and copy information:
    - **a.** I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person
    - **b.** The information makes reference to another person (unless the other person is a healthcare provider) and I have determined, in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to the other person
    - **c.** The request for access is made by your representative and I have determined, in the exercise of professional judgment that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person. If you are denied access, you may request a review of the denial by another licensed medical practitioner. I will comply with the outcome of the review. If your request only concerns billing information, contact NW Clinical Billing 1-800-831-3322.
4. **You have the right to amend confidential information.** If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request and a reason that supports your request must be made in writing and submitted to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:
    a. Was not created by my practice, unless the person or entity that created the information is no longer available to make the amendment. In such instances I would consider the request
    b. Is not part of the information kept by or for my practice
    c. Is not part of the information which you would be permitted to inspect and copy
    d. Is accurate and complete
5. **You have the right to receive an accounting of disclosures of confidential information.** You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to me. Your request must state a time period that may not be longer than six (6) years and indicate what format you want the list (for example on paper or in an electronic file). The first list you request will be free. For additional lists, I may charge you the cost of providing the list. I will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:
    a. To carry out treatment, payment and healthcare operations
    b. To individuals of confidential information about them
    c. As a result of assigned authorization
    d. For the practice's directory or to persons involved in your care
    e. For national security or intelligence purposes; or
    f. To correctional institutions or law enforcement officials
6. **You have the right to obtain a paper copy of this Notice upon request.** Even if you have requested an electronic copy, I will provide you with a paper copy of this Notice at your request.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. I will promptly revise and distribute my Notice whenever there is a change to the uses or disclosures, your rights, and my duties, or other privacy practices stated in this Notice. I will mail updates of my notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. A copy of the current Notice will be available throughout my practice. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

OTHER USES OF INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide my practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that I am required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. You may contact me with questions or comments at (425) 688-1888, or by mail at *Carla Hellekson, M.D.,PLLC*, 1300 114th Avenue SE, Suite 102, Bellevue, WA 98004.

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AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

I authorize *Carla Hellekson, M.D., PLLC* to ☐ release / ☐ obtain information from the records of:

Patient Name: _____ Date of Birth: _____

INFORMATION TO BE EXCHANGED WITH:

Organization/Individual: _____

Mailing Address: _____

Telephone: _____ Facsimile: _____

I authorize my records to be faxed to the number provided above. **Patient Initials:** _____

INFORMATION TO BE EXCHANGED:

☐ Sleep Evaluation, PSG Reports, and Progress notes
☐ Outpatient psychiatric evaluation
☐ PT/OT reports
☐ Inpatient psychiatric discharge summary
☐ Psychological testing/assessment
☐ Laboratory/test reports
☐ Summary of medical or psychiatric history and treatment, including progress notes
☐ Psychiatric treatment/termination summary
☐ Chemical dependency records
☐ Crisis plan
☐ Treatment plan
☐ All records
☐ Progress notes for dates: _____
☐ Psychiatric medical notes for dates: _____
☐ Other: _____

FOR THE PURPOSES OF:

☐ Participation in psychiatric evaluation and/or treatment services
☐ Coordination of care between multiple providers
☐ Transfer of care to a new provider
☐ Other (please specify): _____

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to *Carla Hellekson, MD, PLLC*. I understand that once the information has been released according to the terms of this authorization that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authority at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with Dr. Hellekson has ended or one year after date of last visit, unless otherwise specified here: __

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

CARLA HELLEKSON, MD, PLLC

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DRIVING DIRECTIONS

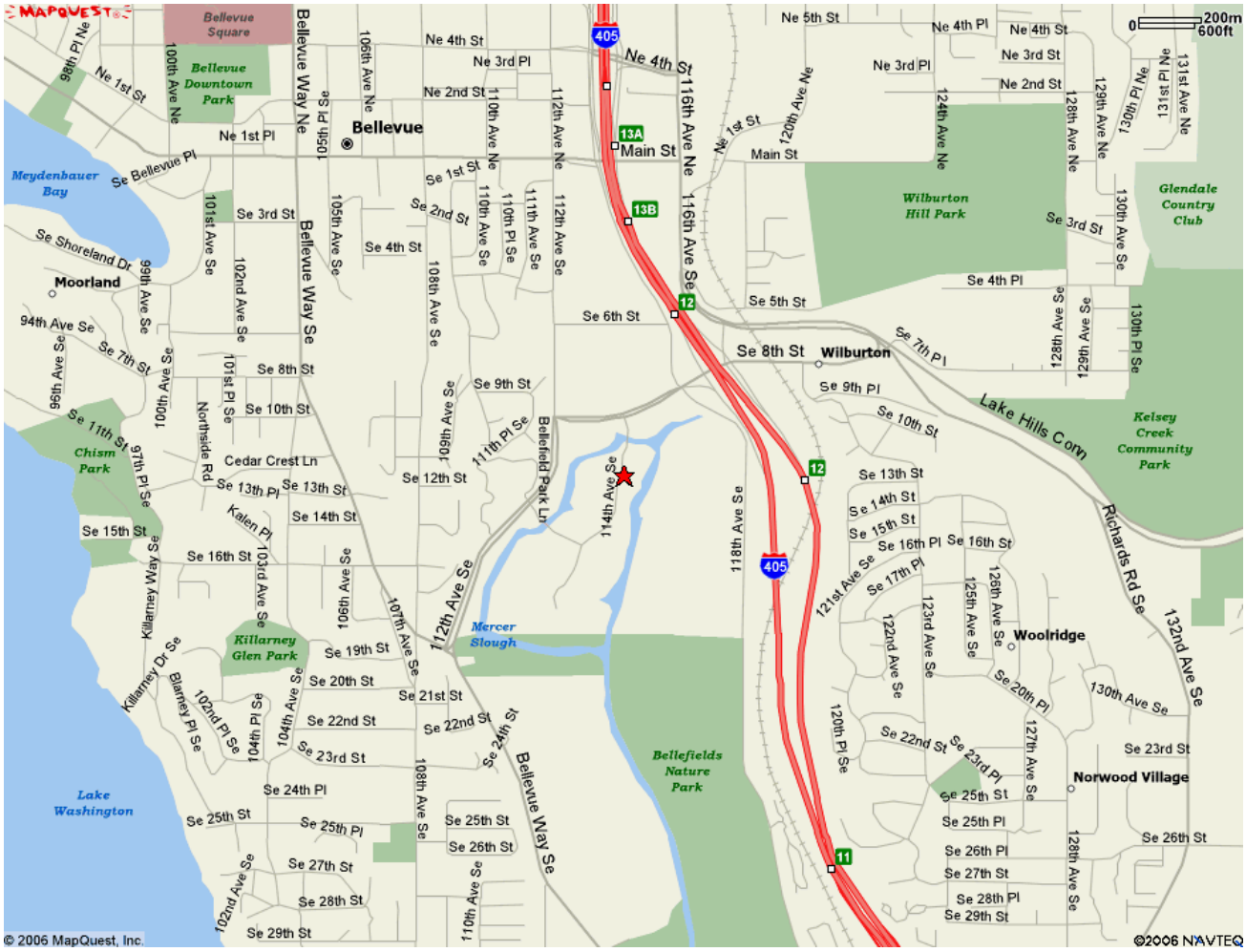
Dr. Hellekson's office is located in the Madrona Building in Bellefield Office Park. The address is:
1300 114th Ave SE, Suite 102, Bellevue, WA 98004

FROM I-405

- Take Exit 12
- Go WEST on SE 8th Street to the 2nd stop light after the stoplight at the end of the exit ramp.
- Turn LEFT onto 114th Avenue SE, the entrance to Bellefield Office Park
- Proceed to the Madrona Building, the 2nd building across the bridge on your LEFT

FROM I-90

- Take Exit 9 to Bellevue Way
- Proceed NORTH past the SE Bellevue P&R and go RIGHT onto 112th Avenue SE
- Turn RIGHT into the Bellefield Office Park entrance
- Go LEFT at the first stop sign
- The Madrona Building at 1300 114th Avenue SE will be on your RIGHT



www.mapquest.com

^ I- 90 Exit 9 onto Bellevue Way