ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF PRIVACY PRACTICES FROM CENTER FOR PROSTHETICS ORTHOTICS

I certify that I have received a copy of CPO’s Summary of Privacy Practices. This Summary of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of CPO’s health care operations. This Summary also describes my rights and CPO’s duties with respect to my protected health information. The complete Notice of Privacy Practices is posted in the CPO waiting room and on CPO’s website at HYPERLINK “http://www.cpo.biz” www.cpo.biz. A complete copy of the Notice of Privacy Practices may be requested from the receptionist.

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RECEIPT OF MEDICARE SUPPLIER STANDARDS DOCUMENTATION

I have received a copy of the CMS MEDICARE DMEPOS SUPPLIER STANDARDS, which every durable medical equipment and prosthetic-orthotic supplier must meet to obtain and retain their billing privileges.

ACKNOWLEDGEMENT OF RECEIPT OF MESSAGE FROM TRICARE

My signature only acknowledges my receipt of the Tricare message (if applicable) from CENTER FOR PROSTHETICS ORTHOTICS, INC. and does not waive any of my rights to request a review or make me liable for any payment.
## Delivery Receipt

### Patient Information

<table>
<thead>
<tr>
<th>Patient Name (Last, First, MI)</th>
<th>Patient ID</th>
<th>Patient DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOIG, IVAN</td>
<td>30364</td>
<td>6/27/1939</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City, State, Zip Code</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>17277 15TH. AVE. N.W.</td>
<td>SHORELINE, WA 98177-3846</td>
<td>USA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K Level</th>
<th>Device Type</th>
<th>Visit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Jewett Brace</td>
<td>Initial Evaluation</td>
</tr>
</tbody>
</table>

### Delivery Location

Seattle Branch: 411 12th Avenue Suite 200, Seattle, WA 98122-5599

### L-Code | Qty | Description/Prescription

| L0472 | 1   | TL50, TRIPLANAR CONTROL, HYPEREXTENSION, RIGID ANTERIOR AND LATERAL FRAME EXTENDS FROM SYMPHYSIS PUBIS TO STERNAL NOTCH WITH TWO ANTERIOR COMPONENTS (ONE PUBIC AND ONE STERNAL), POSTERIOR AND LATERAL PADS WITH STRAPS AND CLOSURES, LIMITS SPINAL FLEXION, RESTRICTS GROSS TRUNK MOTION IN SAGITTAL, CORONAL, AND TRANSVERSE PLANES, INCLUDES FITTING AND SHAPING THE FRAME. PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT |

### Practitioner

Kevin Clark CPO, LPO

### Components Provided

**Delivery Acknowledgement:**
I acknowledge that on today's date, I received the referenced componentry utilized in the fabrication and reimbursement of my device. I am satisfied with both the workmanship and fit of my device and will call Center for Prosthetics Orthotics, Inc. to schedule a return visit if I experience any problems with my device or if I have any questions regarding my service.

I understand that the components of my device are fully guaranteed under normal use for 90 days and that Center for Prosthetics Orthotics, Inc. will make any repairs to my device, as needed, and free of charge during the warranty period. I understand that this does not apply to changes in my physical weight, condition, nor any other physiological changes that may occur, or to any alterations made by anyone other than Center for Prosthetics Orthotics, Inc. In addition, Center for Prosthetics Orthotics, Inc. will not be responsible for abuse or neglect.

I acknowledge that I have received care and use guidelines pertaining to this device (if applicable) as well as supplier standards.

**Release of Benefits and Information:** I authorize my insurance benefits to be paid directly to CPO. I am financially responsible for any balance due. I hereby authorize the release of information to my medical insurance company which may be required by them to process payment for service or to authorize medical treatment or hospitalization.

If patient cannot sign for themselves than a representative payee as designated by the Social Security Admin or a legally appointed guardian may sign. The source of the signatory's authority should be stated, e.g., SS appointed, representative payee, court appointed guardian, etc.

**IVAN DOIG (or guardian)**

**Date**

12/9/14

### Guardian Name | Relationship to Patient

**NOTICE OF CONFIDENTIALITY:** This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.
INFORMED CONSENT

Agreement to Pay for a Non-covered Service or Item

This form, or a similar form, must be completed in full prior to providing a non-covered service or item to any patient including a Medical Assistance client.

Patient/Client Name

I understand that the specific services listed below MAY NOT BE covered by my health insurance and or medical assistance program and are not included as part of another service, or have been determined by my health plan or MAA not to be medically necessary
I choose to receive these specific services
I agree to pay for these specific services

Specific services patient/client agrees to receive and pay for: L0472

This agreement is void and unenforceable, and I am under no obligation to pay the provider, if my health plan covers the services listed above or if the provider fails to satisfy DSHS conditions of payment as described under WAC 388-502.

I understand this form and all my questions were answered to my satisfaction.

Signature of patient/client, parent, guardian, or Representative.  

Date

Signature of Provider/Provider Number

Date

Note to providers: The services or items above must be specific in nature. Document steps taken to assure that the patient/client fully understands this form, and that the form has been interpreted or translated as necessary.

This form was designed to provide information that will satisfy Group Health Cooperative (GHC) contractual requirements and no representations are made that it satisfies any other disclosure obligations a provider may have.

Informed Consent Waiver Form.doc
Distributed September 2005 by GHC Provider Services Department

09/12/08
Patient Financial Responsibility

Patient Information

<table>
<thead>
<tr>
<th>Patient Name (Last, First, MI)</th>
<th>Patient ID</th>
<th>Patient DOB</th>
<th>Device Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOIG, IVAN</td>
<td>30364</td>
<td>5/27/1939</td>
<td>Jewett Brace</td>
</tr>
</tbody>
</table>

We are committed to fully informing you from the outset of the anticipated financial cost to you for our healthcare services before they are rendered to you. You are responsible for payment of your coinsurance and/or any unmet annual deductible upon delivery and any non-covered service. Based on information supplied to us by your insurance carrier(s) and the estimated cost of services that your physician has prescribed, you are financially responsible for the following:

**Prescribed Services**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated total services</td>
<td>$400.32</td>
</tr>
<tr>
<td>Your unmet annual deductible:</td>
<td>$0.00</td>
</tr>
<tr>
<td>Fees after deductible:</td>
<td>$400.32</td>
</tr>
<tr>
<td>P&amp;O co-insurance (20%):</td>
<td>$80.06</td>
</tr>
<tr>
<td>Estimated Insurance Payment</td>
<td>$320.26</td>
</tr>
</tbody>
</table>

**Patient Responsibility**

<table>
<thead>
<tr>
<th>Responsibility Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial responsibility for services:</td>
<td>$80.06</td>
</tr>
<tr>
<td>50% Down:</td>
<td>$40.03</td>
</tr>
<tr>
<td>50% Due at Delivery:</td>
<td>$40.03</td>
</tr>
</tbody>
</table>

Notes:

G.H. AUTH REQ. GP

This is an estimate based on information we have obtained from your insurance provider. ANY REFUND DUE BECAUSE OF YOUR OVERPAYMENT WILL BE DISTRIBUTED 30-45 DAYS AFTER YOUR INSURANCE HAS PAID THEIR PORTION OF YOUR CLAIM.

[Signature]

IVAN DOIG (or guardian)  Date

NOTICE OF CONFIDENTIALITY: This document contains unconditionally private medical records. Any improper use of the information contained herein constitutes a breach of patient medical confidentiality.
Jefferson - across from Seattle
411 12th Ave N
608
15 min, easy
d掉头 前面
10
eria - 
epo. biz
Dear Patient:

The request for coverage of the equipment described below is approved.

Specialty: BRACES/APPLIANCES

Service: L4205 Labor to repair brace

Start date: 11/25/14
End date: 02/24/15

Referring diagnosis: 8054 Broken bone (vertebra), lower back

Supplier:
CTR FOR PROSTHETICS ORTHOTICS-
411 12TH AVE STE 200
SEATTLE WA 98122-5599
206-328-4276

Notes:
Evaluation for back brace. Authorization is pending review of final quote and notes from the evaluation. Some items may not be covered. Please fax final quote to 206-901-4711 or 1-877-290-4632 for final authorization.

Group Health may require approval, in advance, for any services not mentioned in this letter.

This approval is subject to all terms within your benefit booklet (certificate of coverage) or your Clear Care Medicare Advantage Evidence of Coverage, such as benefit limits, out of pocket expenses, and eligibility for coverage. A copy of your benefit booklet (certificate of coverage) or evidence of coverage is available online at www.ghc.org.

If you have questions about this letter or your coverage, please call Customer Service toll-free at 1-888-901-4636 (TTY WA Relay: 1-800-833-6388; TTY ID Relay: 1-800-377-3529), or e-mail us at www.ghc.org/customerservice.

cc: CTR FOR PROSTHETICS ORTHOTICS-
AUTHORIZATION FOR PATIENT SERVICES

- Group Health will provide medical coverage subject to the terms and conditions of the patient's certificate of coverage, including any applicable copayments, deductibles, benefit limits or coinsurance.

- The cost of any goods or services listed on the authorization and provided to the patient after his/her medical coverage is no longer in effect will be the responsibility of the patient.

- The cost of any goods or services provided to the patient, which are not listed on the authorization, will not be covered by Group Health.

- Any non-covered services provided to the patient will be billed by Group Health or the provider in accordance with the terms of the agreement between Group Health and the provider.

PATIENT INSTRUCTIONS:

**General Care:** You must continue to go to your Group Health personal physician or the medical center where your personal physician is located for any additional medical care needs that are not part of the authorization.

**Hospital Care:** Admissions to any facility for inpatient care or for short stay surgery (including hospitals and freestanding ambulatory surgical centers) are not included in this authorization unless otherwise noted.

**Missed/Cancelled Appointments:** You will be responsible for any charges resulting from missed or cancelled appointments in accordance with the provider's policy.

**Prescriptions, laboratory tests, and x-rays:** X-rays, laboratory work and all prescriptions must be obtained at a Group Health medical center or Group Health contracted pharmacy unless otherwise noted. Present this document at the Group Health pharmacy when filling prescriptions ordered by non-Group Health providers. If a prescription is filled elsewhere or the drug is not carried or covered by Group Health, you will be responsible for payment.
Referral Services
P.O. BOX 34589
SEATTLE WA 98124-1585
H5050_PSREFAPRV0909

Patient ID : 00215948
Patient DOB : 06/27/39
Reference : 14564293
Group Number : 0100300
Group Name : PEBB CLASSIC RETIREE
- WEST

November 26, 2014

IVAN C. DOIG
17277 15TH AVE NW
SHORELINE WA 98177
AUTHORIZATION FOR PATIENT SERVICES

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cc: CTR FOR PROSTHETICS ORTHOTICS-
CENTER FOR PROSTHESES ORTHOTICS
PATIENT REGISTRATION FORM

Patient Name: Doig Ivan C.
(LAST) (FIRST) (MIDDLE INITIAL)
Street Address: 17277 15th Ave, NW
City: Shoreline State: WA Zip: 98177
Mailing Address (if different): 
Home Phone: 206 542-6658 Cell: ( ) Date of Birth: 6/27/1939
SS#: 516 / 44 / 4410 Marital Status: S X M W Other: Sex: M X F
Employer: self Work Phone: ( ) same
Referring Dr.: Patricia E. Kato Primary Dr.: same
E-Mail Address: cddoig@comcast.net

EMERGENCY CONTACT INFORMATION
Name: Carol M. Doig Relationship: wife Phone: (206) 542-6658
Name: 
Relationship: 
Phone: ( )

INSURANCE INFORMATION
*** PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST ***
If you are unable to show proof of insurance, you will be responsible for incurred charges
Current Insurance? Yes X No 
Insurance Carrier: Group Health/PEBB Classic Retiree-West
Subscriber Name: Ivan C. Doig DOB: 39/27/ SS#: 516 / 44 / 4410

I currently do not have insurance and will self-pay for my treatment. Yes No 

Are you currently residing in a Skilled Nursing Facility? Yes No X 
Are you currently residing in an Assisted Living or Group Home? Yes No X 
Name of Facility: 
Phone #: ( ) 
Contact person at Facility: 
Title: 

*** Do you currently receive DSHS / Medicaid coupons for health care? Yes No X 
*** If you DO NOT receive DSHS coupons, please read, sign and date the following ***
I am not receiving DSHS medical assistance and I agree to pay for services. If I later become eligible for DSHS medical assistance for the date of this service, I agree to notify the provider’s billing office.
Signature: 
Date: 12/9/14

***** TO OUR MEDICARE PATIENTS *****

Within the past five (5) years, have you received the same or similar items(s)?
Yes No X 
If yes, please describe: 
Date received: _____/_____/
If item was returned, please provide reason: 
Date of return: _____/_____/

MEDICAL HISTORY

Please check all that apply:

☐ Your condition is a result of an accident from employment
☐ Your condition is a result of an auto accident
☐ Your condition is a result of another type of accident

General Health (please circle one): poor good excellent

Activity (please circle one): low medium high

Height: 5 ft 7 in

Weight: 160 lbs  ☐ Recent changes in weight  If so, how much: ___ lbs  ☐ Plus  ☐ Minus

Have you had or do you have any of the following:

☐ HEART PROBLEMS  ☐ HEPATITIS A OR B  ☐ VISION PROBLEMS
☐ HYPERTENSION  ☐ HIV POSITIVE  ☐ PARKINSON DISEASE
☐ VASCULAR DISEASE  ☐ RHEUMATOID ARTHRITIS  ☐ ALZHEIMER DISEASE
☐ STROKE  ☐ OBESITY  ☐ PSYCHIATRIC PROBLEMS
☐ DIABETES  ☐ OSTEOARTHRITIS  ☐ ALCOHOLISM
☐ KIDNEY DISEASE  ☐ PULMONARY DISEASE (TB)  ☐ KNOWN ALLERGIES:

List any other conditions that you feel might affect your treatment (including dates and descriptions of surgeries):

myeloma, under treatment since 2007

Currently taking any medications:

Pomalyst, Cytoxan, Gabapentin, Vitamin D

PLEASE READ THE FOLLOWING, SIGN AND DATE BELOW:

The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges I incur in this office. I authorize my insurance benefits to be paid directly to Center for Prosthetics Orthotics. (Further referred to as CPO). I also authorize CPO to release to my insurance carrier any information required for this claim.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CPO for any services furnished by CPO. I further authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

The patient, if physically and mentally competent, must sign on their own behalf. If they cannot sign for themselves then a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory's authority should be stated; e.g., SS appointed, representative payee, court appointed guardian, etc...

SIGNATURE: ____________________________  DATE: 12 / 9 / 2011

Legally appointed guardian:

Name: ____________________________  Relationship to patient: ____________________________

Signature: ____________________________  Date: ___ / ___ / _______

PLEASE BE SURE YOU HAVE ANSWERED ALL QUESTIONS.
THANK YOU!

rev. 1/14/2011
**PRIVACY RESTRICTIONS**

Please check off:

Do not phone at home
Send all mail to alternate address
Do not leave messages on answering machine or voice mail
At home
On Cell
Do not leave message with individual other than patient
Do not mail reminder postcards
Other privacy request
Restrict communication to the following individuals regarding my treatment and/or appointments. (OK to speak with )

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I have read and understand **Privacy Practices; Medicare Supplier Standards** (copy received); **Privacy Restrictions** and **Tricare message** (if applicable).

12/9/14

Patient’s Signature

Date

************************************************************************************************************************************************************************************************************************************************************************

****

NOTE: IF PATIENT IS UNABLE TO SIGN, PLEASE COMPLETE THE FOLLOWING:
ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY OF PRIVACY PRACTICES FROM CENTER FOR PROSTHETICS ORTHOTICS

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Do not leave messages on answering machine or voice mail
At home
On Cell
Do not leave message with individual other than patient
Do not mail reminder postcards
Other privacy request
Restrict communication to the following individuals regarding my treatment and/or appointments. (OK to speak with)

________________________________________________________________________
Name ___________________________ Relationship ________________
________________________________________________________________________
Name ___________________________ Relationship ________________
________________________________________________________________________
Name ___________________________ Relationship ________________

I have read and understand Privacy Practices; Medicare Supplier Standards (copy received); Privacy Restrictions and Tricare message (if applicable).

________________________________________________________________________

Patient's Signature

________________________________________________________________________

Date

*******************************************************************

****

NOTE: IF PATIENT IS UNABLE TO SIGN, PLEASE COMPLETE THE FOLLOWING:
After-Visit Summary

This is a confidential summary of your visit. It also may include additional information, such as a list of any upcoming lab tests.

Visit Information

Appointment Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Department</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/02/2014</td>
<td>11:00 AM</td>
<td>CSC ONCOLOGY</td>
<td>Eric Y Chen, MD</td>
</tr>
</tbody>
</table>

If you have questions or need further information, call this department at 206-326-3000 or send a secure message to your provider.

PCP and Location

PCP
Patricia E Kato, Physician

Location
NORTHGATE MEDICAL CENTER

Vitals

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Weight</th>
<th>Body Mass Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>120/70</td>
<td>70</td>
<td>163 lb (73.94 kg)</td>
<td>25.34</td>
</tr>
</tbody>
</table>

Reason for Visit

Follow-up Care

Allergies as of 12/2/2014

Allergen
Thalidomide neuropathy

Reactions
Other

Diagnoses

Myeloma - Primary 203.00

Conditions Updated Today

Myeloma

Goals (2 Years of Data) as of 12/2/14

None

Patient Information and Follow-up

Patient Instructions

Diagnosis: myeloma

Today: Please get the following tests done:

- Blood tests

Medicine changes made today:

- No change

Treatment plan:

Doig, Ivan C (MRN 00215848) Printed at 12/2/14 10:55 AM
Patient Information and Follow-up (continued)

Patient Instructions (continued)
- Tests and X-rays: blood work every 4 weeks. Turn in urine test
- Chemotherapy: continue pomalyst and cytoxan
- Follow-up appointments: 4 weeks

Goals of your treatment plan:
Keep you informed, provide you with the best proven treatment options and the best clinical team to personalize your treatment plan. We will help you recognize and minimize symptoms/side effects related to your disease and its treatment.

If you have questions or concerns about your condition or about what we talked about today, please call or send us a secure e-mail and we'll get back to you in 1 business day.

When do I call my Oncology team?
- New persistent pain lasting longer than 2 weeks
- Unexplained weight loss or loss of appetite
- New or worsening shortness of breath
- New swelling in your leg

Visit MyGroupHealth
In the next day or two, your provider’s clinic note from today will be added to the After Visit Summary visible on MyGroupHealth.

Follow-up

Disposition
Return in about 4 weeks (around 12/30/2014).

Test Results
Results From Your Visit
None

Lab Tests Due
This section lists all lab tests you need to do. This may include tests ordered at previous visits. If a listed lab test wasn't done during today's visit, go to any Group Health medical center for that test. Your test should be done on the due date or as soon as possible after that date.

<table>
<thead>
<tr>
<th>Order</th>
<th>Due Date</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>POTASSIUM [84132.001]</td>
<td>11/25/2014</td>
<td>KATO, PATRICIA E</td>
</tr>
<tr>
<td>CBC/PLT/DIFF (GHC) [85025.003]</td>
<td>12/1/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>KAPPA/LAMBDA FREE LIGHT CHAINS W/RATIO (GHC) [83883.004]</td>
<td>12/1/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>CREATININE [82565.002]</td>
<td>12/1/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>CALCIUM [82310.001]</td>
<td>12/1/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>ELECTROPHORESIS SERUM PROTEIN (GHC) [84165.003]</td>
<td>12/1/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>CBC/PLT/DIFF (GHC) [85025.003]</td>
<td>12/2/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
</tbody>
</table>
Lab Tests Due (continued)

<table>
<thead>
<tr>
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<td>12/2/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>KAPPA/LAMBD A FREE LIGHT CHAINS W/RATIO (GHC) [83883.004]</td>
<td>12/2/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>CREATININE [82565.002]</td>
<td>12/2/2014</td>
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</tr>
<tr>
<td>CALCIUM [82310.001]</td>
<td>12/2/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
<tr>
<td>ELECTROPHORESIS-URINE PROTEIN (GHC) [84165.004]</td>
<td>12/2/2014</td>
<td>CHEN, ERIC Y</td>
</tr>
</tbody>
</table>

Health Reminders

**Appointments**

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Provider</th>
<th>Department</th>
<th>Dept Phone</th>
<th>Type of Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/2/2014 11:00 AM</td>
<td>Chen, Eric Y, MD</td>
<td>Capitol Hill Oncology/Hematology</td>
<td>206-326-3000</td>
<td>Office Visit</td>
</tr>
<tr>
<td>1/6/2015 2:45 PM</td>
<td>Shors, Andrew R, MD</td>
<td>capitol Hill Dermatology</td>
<td>206-326-3000</td>
<td>Office Visit</td>
</tr>
</tbody>
</table>

Health Maintenance

Please contact Primary Care for more information about your next colon cancer screening test.

Please visit Primary Care to receive overdue immunizations as soon as possible:

- A Tdap vaccine to protect against whooping cough (pertussis), tetanus, and diphtheria.

- A Shingles (Herpes Zoster) vaccine to protect against shingles

Upcoming Lab Tests

This section lists all lab tests you need to do after today. This may include tests ordered at previous visits. Go to any Group Health medical center for these lab tests. Your test should be done on the due date or as soon as possible after that date.

**Upcoming Orders**

<table>
<thead>
<tr>
<th>Order</th>
<th>Frequency</th>
<th>Available</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALCIUM</td>
<td>Every 4 Weeks</td>
<td>12/29/14</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CBC/PLT/DIFF (GHC)</td>
<td>Every 4 Weeks</td>
<td>12/29/14</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CREATININE</td>
<td>Every 4 Weeks</td>
<td>12/29/14</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>ELECTROPHORESIS SERUM PROTEIN (GHC)</td>
<td>Every 4 Weeks</td>
<td>12/29/14</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>KAPPA/LAMBD A FREE LIGHT CHAINS W/RATIO (GHC)</td>
<td>Every 4 Weeks</td>
<td>1/26/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CALCIUM</td>
<td>Every 4 Weeks</td>
<td>1/26/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
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<tr>
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<td>1/26/15</td>
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</tr>
<tr>
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<td>Every 4 Weeks</td>
<td>1/26/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
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<td>Every 4 Weeks</td>
<td>1/26/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CALCIUM</td>
<td>Every 4 Weeks</td>
<td>2/23/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CBC/PLT/DIFF (GHC)</td>
<td>Every 4 Weeks</td>
<td>2/23/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CREATININE</td>
<td>Every 4 Weeks</td>
<td>2/23/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>ELECTROPHORESIS SERUM</td>
<td>Every 4 Weeks</td>
<td>2/23/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
</tbody>
</table>
Upcoming Lab Tests (continued)

Upcoming Orders (continued)

<table>
<thead>
<tr>
<th>Order</th>
<th>Frequency</th>
<th>Available</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROTEIN (GHC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAPPA/LAMBD A FREE LIGHT</td>
<td>Every 4 Weeks</td>
<td>2/23/15</td>
<td>Chen, Eric Y, MD</td>
</tr>
<tr>
<td>CHAINS W/RATIO (GHC)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Updated Medication List

This section lists the medications you have reported you are currently taking, as well as new medications and supplies ordered and changes made at this visit.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosing Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>pomalidomide (POMALYST) 4 mg capsule</td>
<td>Take 1 capsule (4 mg) by mouth daily for 21 days, then stop for 7 days</td>
</tr>
<tr>
<td>furosemide (LASIX) 20 mg tablet</td>
<td>Take 3 tablets in the morning and 2 tablets in the afternoon for swelling.</td>
</tr>
<tr>
<td>potassium chloride (K-TAB) 10 mEq extended release tablet</td>
<td>Take 3 tablets in the morning and 2 tablets in the afternoon with Furosemide.</td>
</tr>
<tr>
<td>cyclophosphamide (CYTOXAN) 50 mg capsule</td>
<td>Take 8 capsules (400mg) by mouth once a week and day 1, 8 and 15 of 28 day chemotherapy cycle.</td>
</tr>
<tr>
<td>senna (SENN A) 8.6 mg tablet</td>
<td>Take 1 tablet (8.6 mg) by mouth daily</td>
</tr>
<tr>
<td>calcitonin (salmon) (FORTICAL) 200 unit/actuation nasal spray</td>
<td>1 SPRAY IN ONE NOSTRIL DAILY, ALTERNATE NOSTRILS EACH DAY</td>
</tr>
<tr>
<td>gabapentin (NEURONTIN) 300 mg capsule</td>
<td>TAKE 1 CAPSULE (300 MG) BY MOUTH 3 TIMES DAILY</td>
</tr>
<tr>
<td>glucosamine-chondroitin 500-400 mg capsule</td>
<td>Take 1 capsule by mouth 3 times daily (1500 mg of glucosamine and 1200 mg of chondroitin per day)</td>
</tr>
<tr>
<td>calcium carbonate (CALTRATE 600) 600 mg (1,500 mg) tablet</td>
<td>Take 1 tablet by mouth 2 times daily (1200 mg per day)</td>
</tr>
<tr>
<td>cholecalciferol (VITAMIN D) 1,000 unit capsule</td>
<td>Take 5 tablets (5,000 Units) by mouth daily</td>
</tr>
</tbody>
</table>

Health Profile

Remember to fill out a Health Profile every year. You'll get an updated, personal report with suggestions on how to improve your health and lower your risk of certain diseases. You also can compare your reports from year to year. The Health Profile link is on your home page.
Account number: 000027119  
Invoice date: 10/23/2014

CAROL D DOIG  
17277 15TH AVE NW  
SHORELINE WA 98177-3846

This is your invoice for Public Employees Benefits Board (PEBB) insurance coverage for November 2014.

| Previous balance: | .00 |
| Premium for Group Hlth Medicare: | 283.36 |
| Premium for Uniform Dental Plan: | 89.44 |

Total due: $ 372.80  
Payment due date: 11/15/2014

Please pay the total amount due. Include the payment coupon below, and mail in the enclosed envelope to:

Health Care Authority  
P.O. Box 34270  
Seattle, WA 98124-1270

If you have questions about your account or this invoice please call us at 1-800-200-1004 or 360-725-0440, Monday through Friday, 8 a.m. to 5 p.m.

(continued on back)
Want to go paperless?

If you no longer wish to receive a paper invoice, our electronic debit service allows you to pay your monthly insurance premium and any applicable surcharges by automatically deducting payment from your savings or checking account. For information, call 1-800-200-1004 or go to www.hca.wa.gov/pebb and select Get a Form to print the Electronic Debit Service Agreement form.

How to make changes to your account

To protect your rights and the rights of your family, keep the PEBB Program informed of address changes. If you have a change in status, or you would like to cancel your PEBB insurance coverage, contact us at 1-800-200-1004 or 360-725-0440 in Olympia (TTY: 711) Monday - Friday, 8 a.m. - 5 p.m.

To cancel your PEBB retiree, COBRA, or PEBB Extension of Coverage, or Leave Without Pay coverage, you must submit your request in writing to:

Health Care Authority
PEBB Program
P.O. Box 42684
Olympia, WA 98504-2684

Plan enrollment will end on the last day of the month in which we receive your written request to cancel.
KEVIN J CLARK, LPO, CPO
Licensed Prosthettist-Orthotist
American Board Certified

411 12th Avenue, Suite 200
Seattle, WA 98122-5599
(206) 328-4276 phone
(206) 328-1037 fax
(800) 474-4CPO (4276)

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