



PATIENT APPOINTMENT CHECKLIST complete everything & fax to us/bring with you

Welcome to the Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery. Our staff looks forward to providing you with exceptional medical care and excellent customer service. In order to serve you best, we have assembled all your preliminary forms into this convenient package. Please complete them either by printing them out and filling them in by hand, or by filling in the PDF's fields in Adobe Reader and then printing out the results, which you can then fax to us at 310-314-2414 or bring to your appointment. Either way, please have your forms complete by the time of your appointment. If you have any questions regarding these forms, please contact us at 310-314-6410 between 9AM-5PM weekdays.

Please arrive on time for your scheduled appointment. If you are more than 20 minutes late, your appointment will be cancelled and rescheduled for a later date.

Our office requires a credit card or debit card to be on file in order to confirm your appointment. Unless you have provided this guarantee, please do not consider your appointment time to be reserved. If you need to cancel your appointment, please contact our office within 48 hours of your scheduled appointment time or you will be charged a \$100 cancellation fee.

Please note you will be in the office at least TWO HOURS. Incomplete paperwork will delay your appointment.

1. **IDENTIFICATION:** Bring ALL insurance cards, referral forms, and authorizations. In addition, bring the name of the physician currently treating you and their contact information.

2. **DIAGNOSTIC IMAGES: BRING ALL DIAGNOSTIC IMAGES AND REPORTS**

While reviewing all imaging is sometimes beneficial, ONLY, reports and images conducted within the current year are necessary. Requests for extensive review for testing over one year old will incur additional charges. Please utilize the subsequent list to ensure that you have all of the images needed for a comprehensive examination. **IF YOU DO NOT HAVE ALL OF YOUR IMAGES AND REPORTS, YOU WILL DELAY THE START OF YOUR TREATMENT PLAN,** as an additional appointment will be necessary to complete your initial procedure plans.

- MRN
- MRI
- C.T.
- X-ray
- Ultrasound
- Nuclear Medicine
- Dexa
- DOS _____ (month / day / year)

3. **PROCEDURE, INTERVENTION OR SURGERY REPORTS:** Bring ALL treatment reports and referring physician tests pertaining to body regions involved in your reason for consultation. Please refer to the following list to ensure that you have all reports needed for a complete evaluation.

- Outpatient surgery report
- Inpatient surgery report
- Spinal Nerve Blocks
- Epidural Blocks
- RF and Fluro guided injections
- DOS _____ (month / day / year)

LOCATION AND PARKING: The Institute for Nerve Medicine and The Center for Advanced Spinal Neurosurgery is located at 2716 Ocean Park Blvd., Suite 3082, Santa Monica, California, on the south side of Ocean Park Boulevard, just west of 28th Street. Parking is in the back of the building entering off 28th Street. We do not offer parking validation, so please be prepared to pay for your parking fees. As there is a long waiting list for appointments, if you are unable to keep your appointment, please call our office (310-314-6410) to reschedule as soon as possible. Thank you for choosing our medical office to provide your care. We look forward to seeing you in our office soon.



INSTITUTE FOR NERVE MEDICINE

**CENTER FOR ADVANCED
SPINAL NEUROSURGERY**

2716 OCEAN PARK BLVD., SUITE 3082
SANTA MONICA, CA 90405
310-314-6410
nervemed.com espinehealth.com

Aaron Filler, MD, PhD

PATIENT INFORMATION

Date: _____ Home Phone: _____
 Patient: _____ Soc.Sec.: _____
 Address: _____ Email: _____
 City: _____ State: _____ Zip: _____
 Sex: M F Age: _____ Birthdate: _____ Single Married Widowed Divorced
 Patient Employer: _____ Occupation: _____
 Business Address: _____ Bus. Phone: _____
 Referring Physician: _____ Phone: _____
 Address: _____ Fax: _____
 Primary Care Physician: _____ Phone: _____
 Address: _____ Fax: _____
 Pain Management Doctor: _____ Phone: _____
 Address: _____ Fax: _____
 Reason for visit: _____

OTHER INFORMATION

Person Responsible for Account: _____ Phone: _____
 Relationship to Patient: _____ Soc.Sec.: _____ Date of Birth: _____
 Address (if different from patient): _____
 Person Responsible Employed By: _____ Phone: _____
 Is this a work-related injury? Yes No If Yes, please fill out Workers Compensation Information below
 Is this case under litigation? Yes No Attorney's Name: _____
 Attorney Address: _____ Phone: _____
 In case of emergency who should we notify?: _____ Phone: _____

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____
 Claims Address: _____
 Insured Name: _____ Date of Birth: _____
 Contract #: _____ Group #: _____ Subscriber #: _____

WORKERS COMPENSATION INSURANCE

Employer's Name: _____ Phone: _____
 Date of Injury: _____ Claim #: _____
 Worker Compensation Carrier: _____
 Carrier Address: _____
 Adjuster's Name: _____ Carrier Phone: _____
 Coverage Verified By: (Office Use Only) _____ Carrier Fax: _____

Please continue to the second page of this form



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ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assigned directly to The Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

In the event that my health insurance sends me a check in my name that has been issued to reimburse the costs of these health care services, I agree to endorse over the check to INM/CASN by writing on the back of the check "Pay to Institute for Nerve Medicine" and signing immediately below this statement. I will then send the check with this endorsement to INM at 2716 Ocean Park Blvd., Suite 3082, Santa Monica, CA 90405.

I further understand that Dr. Aaron Filler is not a provider of services with my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date: _____

OPT-OUT PROVIDER MEDICARE ADVISORY

I, the undersigned, gives up all Medicare payment for services furnished by the "opt out" physician; agrees not to bill Medicare or ask the physician to bill Medicare; is liable for all of the physician's charges, without any Medicare balance billing limits; acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

Signature: _____ Date: _____

**SPECIAL NOTICE TO GOVERNMENT EMPLOYEES, MILITARY
& ARMED FORCES PERSONNEL (ACTIVE & RETIRED)**

Insurances like TriWes Care may require contracting for your reimbursement. Please be advised that this provider does not contract with any insurance carrier. This medical practice has opted out of Medicare; the provider has a deactivated UPIN number. Your signature acknowledges that we will not sign a contract for your insurance payment.

Signature: _____ Date: _____



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PATIENT FINANCIAL RESPONSIBILITY

The Institute for Nerve Medicine is pleased to provide medical care for you today. It is our goal to make available to each patient the quality medical care they deserve. As our patient please be advised that Dr. Aaron Filler is not a contracted or participating provider with your insurance network and, it is ultimately your responsibility that The Institute for Nerve Medicine is fully reimbursed for the services provided.

If you are using insurance for your medical treatment, it is your responsibility to know the terms and conditions of your coverage and to provide us with a copy of your most current insurance card. Keep in mind, you do have the right to decline services recommended by a provider. If our service(s) is not covered by your insurance or if your insurance coverage has lapsed, you will be personally responsible to pay for that service in full. Payment will be processed from the credit card authorization on file and any installment payment arrangements must be made in advance of services provided, and for established patients please note that partial payments can not be made once insurance has been finalized. Please note that you will receive a statement from us even though we have billed your insurance carrier.

ASSIGNMENT OF BENEFITS FORM

We will be happy to bill your insurance for your medical charges, but in order to do so we must have your signature below authorizing the Assignment of Benefits. If we do not have your signature below, we cannot bill your Insurance and the total charge will be due from you. We thank you for your prompt cooperation.

I hereby assign to Aaron Filler, MD, PhD, APC DBA The Institute for Nerve Medicine, 2716 Ocean Park Blvd, #3082, Santa Monica, CA 90405, all my rights, title and interest to any and all health care and/or surgical benefits otherwise payable to me for medical treatment, including major medical, rendered by the assignee effective as of the below stated date and as described in the any subsequent medical claim forms for services provided.

I authorize and direct my insurance carrier to make all payments directly to the provider, I surrender and assign all right, title and interest I may have in any benefits or payments and in any interest on late payments that are paid by check written out to me or to the primary insurance member who is responsible for my coverage as custodian of the funds due to the provider. When my insurer includes the provider's Tax ID to the IRS on a 1099 basis in relation to any payment for medical services under my health insurance, I agree to immediately turn over any such funds to the provider associated with that Tax ID. If I do not immediately turn over the funds, I agree to reporting to the IRS and State tax authorities as well as to law enforcement within two weeks of the receipt of any such funds intended for the provider.

By affixing your signature below you are affirming your acceptance of services, you acknowledge that you are financially responsible for all services provided by The Institute for Nerve Medicine.

Patient Signature: _____ Date: _____
(Or responsible party)**

Print Name: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize THE INSTITUTE FOR NERVE MEDICINE to furnish medical information concerning my care to my referring physician and 3rd Party Payers including bank and credit card companies. Any and all information may be released, including but not limited to mental health records protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if any except as specifically provided below: _____

This information may be used only for the following purposes:* Diagnosis and Treatment, Payment by 3rd Party Payer. This authorization is effective now and will remain in effect indefinitely until I decide to change it by providing written authorization to comply with HIPAA rules and regulations. I understand that I have the right to receive a copy of this authorization.

Patient Signature: _____ Date: _____
(Or responsible party)**

Print Name: _____



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PAYMENTS AND FINANCING

Payment is due at the time medical service is rendered. Our office is pleased to accept VISA, MasterCard, and American Express in addition to your personal check.

We are pleased to provide medical care for you. It is our goal to make available to each patient the quality medical care they deserve. As our patient, please be advised that this practice is not a contracted or participating provider with your insurance network and, it is ultimately your responsibility that we are fully reimbursed for the services provided.

Our billing service is offered as a courtesy and convenience for processing your insurance. If you are utilizing insurance for your medical treatment, it is your responsibility to know the terms and conditions of your coverage and to provide us with a copy of your most current insurance card. Please keep in mind that if our service(s) is not covered by your insurance or if your insurance coverage does not fully cover the total billed charges, you will be personally responsible to pay for that service in full. Other persons providing payment on your behalf are asked to also sign the payment policy form otherwise we will not be able to accept their payment on your behalf. Optional payment plans such as monthly payments can be made until insurance is finalized but for no longer than one year beyond the date of service. Payment arrangements must be made in advance of services provided.

Patient Signature: _____ Date: _____
(Or responsible party)**

Print Name: _____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: _____ Date: _____

Print Name: _____

FOR BLUE CROSS PATIENTS ONLY

In some cases, health insurance coverage for a non-contracted provider such as INM results in the insurer sending the reimbursement check to the patient/subscriber rather than sending it to the physician. In that case, I agree to sign the check over to INM and send the check to INM and agree not to deposit or cash it on my own behalf.

Patient Signature: _____ Date: _____
(Or responsible party)**

Print Name: _____



HOW MUCH WILL THIS COST?

Each week we get several hundred inquiries asking us how much these services cost. If we have not already seen you as a patient, then it is very difficult to tell you exactly what your care will cost. In fact most providers will not be able to tell you because there is no way of knowing what the confirmed diagnosis or resulting service action may be. Instead we can obtain a courtesy general benefit disclosure and tell you what your insurance will cover according to the type of plan you have chosen. As part of our response we also tell patients that Dr. Aaron G. Filler is not a contracted insurance provider so medical services received through the neurological practice of Institute for Nerve Medicine would be covered at the out of network benefit rate for your insurance plan.

Many patients concerned with out of pocket amounts are frustrated by the out of network status and incorrectly assume that this is a way for the doctor to charge more for the medical service. At the Institute for Nerve Medicine, being out of network is not a way to get more money rather it is a quality of care issue. Many insurance plans will only provide basic services from alternate methods or means that have failed to work. Since we have pioneered many of the medical treatments in this subspecialty field, we stand by our need to be able to provide the best in quality care and to exceed the medical standard of care. Having set the standard of care high, many patients are surprised to learn the value of our medical services. A comprehensive consult in our clinic is only \$500 and this is the price that has not changed in over 6 years despite many medical specialties routinely charging between \$800 and \$1200.

We value our exceptional clinical standards and stand by our successful and objective formal patient outcomes as recorded in numerous peer reviewed papers touting. Our methods are often mimicked but never successfully achieved within network. A good question to ask yourself is how successful the in-network treatments have been at resolving the pain conditions? So if you are concerned about going out of network and are debating the merits of how to best use your resources, please know that 'worth' is not necessarily about money rather it is also the value of the medical service being provided. We are proud to consistently exceed the standard of care and look forward to working with all prospective patients to ensure that the value of our services are available to everyone.

Treatment of complex medical conditions: The diagnosis and treatment of medical conditions is an effort by a physician to determine what is causing your symptoms and to provide treatments that are expected to help resolve the problem. This practice specializes in treating patients with complex and difficult problems by obtaining technologically advanced diagnostics and using technologically advanced treatment methods guided by a physician who is a very knowledgeable expert and leader in the field of complex nerve and spine disorders. By signing below, you acknowledge that you understand that there is no 100% guarantee of cure. The services provided are the best efforts available to try to find and confirm the cause of your disorder and to carry out the indicated treatments with the utmost of care.

Patient Signature: _____ Date: _____

Print Name: _____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: _____ Date: _____

Print Name: _____



FEES & FINANCING

As patients consider care from Aaron G. Filler, MD, they frequently ask for information about the various payment options. We hope the following information and fee estimates are helpful and informative.

As a Non-Contracted Provider, please be advised that we do not share an insurance contract with your insurance carrier. Some insurance plans do not allow you to go out of network and those that do may have a lower reimbursement rate, meaning a greater out-of-pocket expense to you. Moreover, the usual and customary percentage rate that is set by your carrier does not apply to a non-contracted provider.

After your calendar-year deductible is met, your carrier will reimburse you according to their fee schedule which we are not bound to. We cannot provide insurance appeals or participate in any insurance grievance that you may initiate with your insurance carrier. It is imperative that you contact the 800 numbers on the back of your insurance card(s) for the correct percentage reimbursement for all procedures, interventions or surgeries. We provide live internet connectivity for online insurance inquiries to your insurance carrier from within our offices.

Since you have made the decision to go out of network, you have the responsibility for being informed about your insurance policy and its payment benefits. Our office is not responsible for any payment denials or reduction in fee payments that your plan may apply. Any insurance appeals or grievances that you may have with your carrier does not preclude prompt payment to our office.

ESTIMATED FEE SCHEDULE

Super bill Estimates with CPT codes and charges for your procedure are provided at the time of procedure order. Please be advised that these are estimates ONLY and that medical service charges can only be confirmed upon conclusion of the procedure. Any hospital, surgi-center facility and radiological or anesthesia services are separate from these professional fee estimates.

The following represents a summary of some of our most frequently ordered procedures, and their estimates costs:

Open MR-guided procedure Piriformis / Pudendal: \$2900 to \$3900

Open MR-guided procedure TOS or Scalene: \$3500 to \$5000

Open MR-guided procedure Spine: \$1900 to \$3250

Piriformis Surgery: \$8000 to \$12,000

Brachial Plexus Surgery: \$15,750 to \$20,000

Re-Operative Spine Surgery: \$20,000 to \$35,000



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PAYMENT & FINANCING

Payment for injections and surgery are due in full at the time of scheduling for your procedure. In order to confirm your appointment for procedures, interventions or surgeries, payment must be received by our billing office. We provide a number of payment options which may be used individually or combined, according to your wishes.

Our financial coordinators are readily available to meet with you personally to provide the specific information you desire.

Cash or Check: Personal check, cashier’s check or cash

Financing Applications: Detailed information and applications for these companies are available from our patient coordinators. They can assist you in the process of obtaining your preferred financing option by calling us at 866-41-NERVE.



The Institute for Nerve Medicine and the
Center for Advanced Spinal Neurosurgery
accept these as methods of payment

PLEASE READ THE FOLLOWING NOTICE AND SIGN BELOW

The Institute for Nerve Medicine is a neurosurgical practice. By signing below, I indicate my understanding that the Institute for Nerve Medicine (INM) is a professional neurosurgical practice. The physician you see may order specialized diagnostic tests to be done at other facilities including MR Neurography studies offered by a separate radiological practice, which is the Neurography Institute (NIMA).

If specialized interventional diagnostics or treatments are carried out, you may require services at a separate medical facility such as Cedars Sinai Medical Center (for open surgery) or at the Image Based Surgicenter (for MRI Guided interventional diagnostics and/or surgery).

You may expect to receive separate billing from 1) your physician for professional services 2) any diagnostic facility for diagnostic MRIs, MRN's, X-rays and CT scans and 3) any interventional facility for operating room, inpatient hospital or outpatient surgicenter charges.

Patient Signature: _____ Date: _____

Print Name: _____

OTHER PARTY PROVIDING PAYMENT ON YOUR BEHALF:

Payer Signature: _____ Date: _____

Print Name: _____



CREDIT CARD AUTHORIZATION FORM

CREDIT CARDHOLDER INFORMATION						
NAME ON CREDIT CARD						
TYPE OF CREDIT CARD		VISA	MC	AMEX	DISCOVER	OTHER
TYPE OF ACCOUNT			PERSONAL		BUSINESS/ COMPANY NAME	
ACCOUNT NUMBER						
EXPIRATION DATE/ CVS code						
BILLING ADDRESS						
CITY		STATE		ZIP CODE		
PHONE		EMAIL		FAX NUMBER		

AUTHORIZED USER OF CREDIT CARD	
NAME/ RELATION TO OWNER	
PHONE NUMBER/ EMAIL ADDRESS	
AUTHORIZED AMOUNT	

AUTHORIZATION OF CARD USE	
Auto Charge Authorization: to sign up for this monthly service please sign below.	
I hereby authorize the Institute for Nerve Medicine to charge my credit/debit card to pay charges as they become due. This authorization shall remain in effect unless revoked by me in writing and until Institute for Nerve Medicine confirms receipt of such notice. Institute for Nerve Medicine assumes no responsibility for penalties, interest, late fees and bank service charges associated with use of this credit/debit card payment. This authorization shall be effective only upon receipt by Institute for Nerve Medicine. Please note your auto credit card payment will include any and all past due charges , including any charges that may be past due at the time of you sign up for this service. "past due" is defined as 31 days or more from the date of service.	
CARD HOLDER NAME	
SIGNATURE	DATE
I certify that I am the authorized holder and signer of the credit card referenced above.	
I certify that all information above is complete and accurate.	
I hereby authorize collection of payment for all charges as indicated above.	

CARDHOLDER NAME	
SIGNATURE	DATE



PAIN-FUNCTIONAL QUESTIONNAIRE

Patient's Name: _____ Date: _____

Date of Birth: _____ How long have you been in pain? Years ____ Months ____ Weeks ____

Note: you may be asked to complete this form on subsequent visits during your treatment.

Please read prior to filling out questionnaire: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which mostly closely describes your problem.

Section 1 - Pain Intensity

- I can tolerate the pain I have without having to use pain killers
The pain is bad but I manage without taking pain killers
Pain killers give complete relief from pain
Pain killers give moderate relief from pain
Pain killers give very little relief from pain
Pain killers have no effect on the pain and I don't use them

Section 6 - Standing

- I can stand as long as I want without extra pain
I can stand as long as I want with a little pain
Pain prevents me from standing for more than one hour
Pain prevents me from standing for more than 30 minutes
Pain prevents me from standing for more than 10 minutes
Pain prevents me from standing at all

Section 2 - Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
I can look after myself normally but it causes extra pain
It is painful to look after myself and I am slow and careful
I need some help but manage most of my personal care
I need help every day in most aspects of self care
I do not get dressed, wash with difficulty and stay in bed

Section 7 - Sleeping

- Pain does not prevent me from sleeping well
I can sleep well only by using tablets
Even when I take tablets, I have less than six hours of sleep
Even when I take tablets, I have less than four hours of sleep
Even when I take tablets, I have less than two hours of sleep
Pain prevents me from sleeping at all

Section 3 - Lifting

- I can lift heavy weights without extra pain
I can lift heavy weights but it gives extra pain
Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on the table
Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
I can lift only very light weights
I cannot lift or carry anything at all

Section 8 - Sex Life

- My sex life is normal and causes no pain
My sex life is normal but increased on the degree of pain
My sex life is nearly normal but it is very painful
My sex life is nearly absent because of pain
Pain prevents me from any sex life at all

Section 4 - Walking

- Pain does not prevent me from walking any distance
Pain prevents me from walking more than 1 mile
Pain prevents me from walking more than one-half mile
Pain prevents me from walking more than one-quarter mile

Section 9 - Social Life

- My social life is normal and give me no extra pain
My social life is normal but increases the degree of pain
Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, sports, etc.
Pain has restricted my social life and I do not go out as often
Pain has restricted my social life to my home
I have no social life because of pain

Section 5 - Sitting

- I can sit in any chair as long as I like
I can only sit in my favorite chair as long as I like
Pain prevents me from sitting for more than one hour
Pain prevents me from sitting for more than 30 minutes
Pain prevents me from sitting for more than 10 minutes
Pain prevents me from sitting at all

Section 10 - Traveling

- I can travel anywhere without extra pain
I can travel anywhere but it give me extra pain
Pain is bad but I manage journeys over two hours
Pain restricts me to journeys of less than one hour
Pain restricts me to short, necessary journeys under 30 minutes
Pain prevents me from traveling except to the doctor or hospital

Adapted and modified Owesry Pain Scale for Outcome Analysis, Physiotherapy, August 1980, vol 66:8

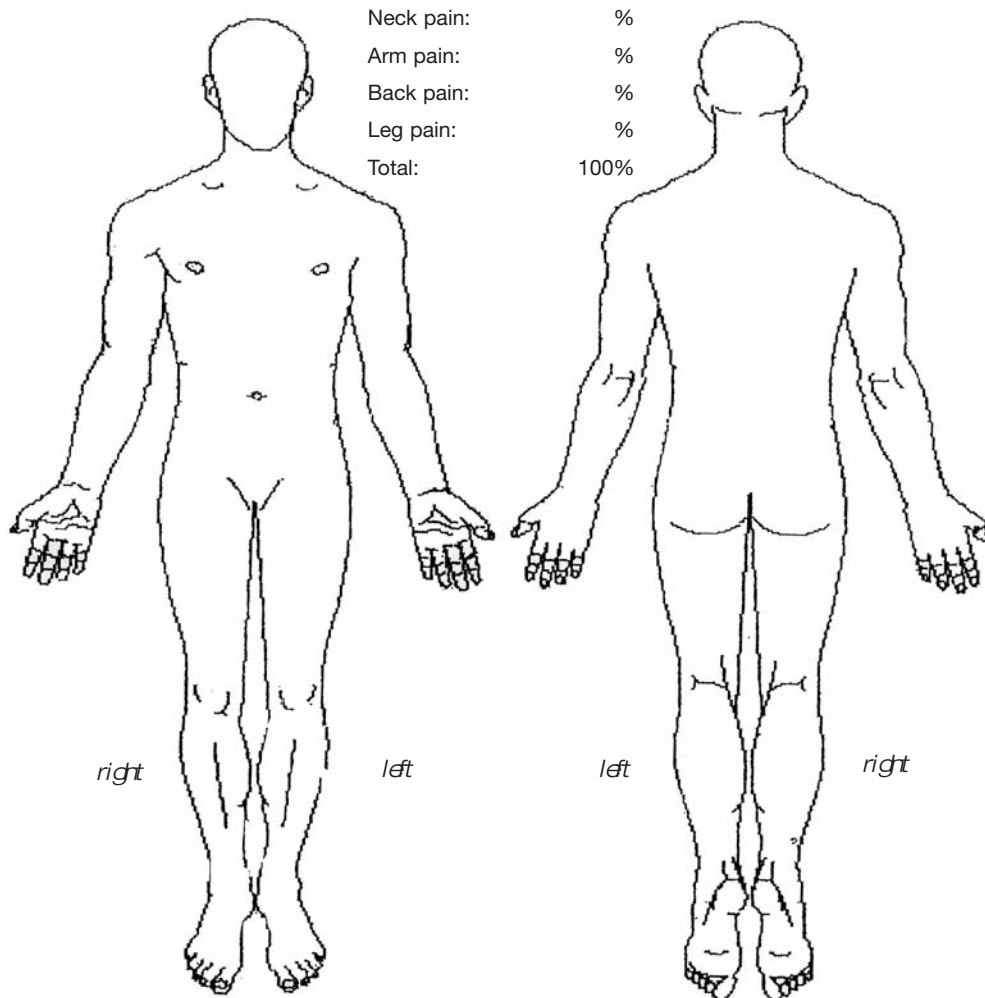
PAIN LOCATIONS

Patient's Name: _____ Date: _____

Age: _____

Where is your pain now? Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation using the symbols indicated below. Include all affected areas. Just to complete the picture, please draw in your face.

active pain	^^^^ ^^^^	numb	0000 0000	pins & needles	◆◆◆◆ ◆◆◆◆	burning	XXXXX XXXXX	radiating pain	////// //////
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How bad is your pain right now? (1=no pain 10=worst pain)

1 2 3 4 5 6 7 8 9 10

How bad is your pain at its worst?

How bad is your pain at its best?

1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10

How consistent is your pain now?

Continuous Positional Intermittent (on/off) Unable to rate



TREATMENT INTENSITY SCORE

Patient's Name: _____ Date: _____

Date of Birth: _____

Please answer the questions below, choosing the answer that most closely describes your situation at the present time. We understand there may be one or more alternatives that may apply to you. Please choose the one you feel is most descriptive of your problem.

1. What medications are you taking for your pain?
 - a. None
 - b. Tylenol, Aspirin, Motrin, Aleve or other non-prescription pain medication
 - c. Vicodin, Codeine, Darvocet, Ultram
 - d. Medrol Dose Pack Morphine Analogs (Oxycontin, MS Contin, Percocet, etc.)

2. How long is the pain relieved before you need medication again?
 - a. 24 hours or more (rarely take medication)
 - b. 12 hours
 - c. 8 hours
 - d. 6 hours
 - e. 4 hours
 - f. Less than 4 hours

3. How long have you taken these medications?
 - a. Use them occasionally only (i.e. do not need them every day)
 - b. 6 weeks
 - c. 3 months
 - d. 6 months
 - e. 1 year
 - f. 2 years or more

4. Have you needed to seek other treatment options, specifically because of the pain in your neck, shoulder, arms, buttocks, legs or back?
 - a. None
 - b. Massage therapy, Shiatsu, Acupressure, etc.
 - c. Supervised Physiotherapy and/or Chiropractor
 - d. Acupuncture, Acupressure, Alternative Medicine Therapies
 - e. Injections such as Nerve Root Blocks or Epidural Steroids
 - f. Spinal Cord Stimulator, Morphine Pump

5. How often have you had to see a Doctor, Therapist, or gone to the Emergency Room, specifically because of unbearable pain (please don't include/disregard any routine follow-up visit)?
 - a. Never
 - b. Once in 6 months or less
 - c. Once in 3 months
 - d. Every 6 weeks
 - e. Every week or 2-3 times a week
 - f. Needed admission to the hospital for severe pain