

Jonathan Collin, M.D.

12911 – 120TH Ave NE Ste A-50
Kirkland WA 98034 U.S.A.
(425) 820-0547 Fax (425) 820-0259

01 April, 1988

Re: Medicare Prohibition of Billing for “Medically Unnecessary” Services

Fellow of the American College
for the Advancement of Medicine

Dear Medicare Patient:

In October, 1987, U.S. Congress passed the Omnibus Budget Reconciliation Act of 1986 (OBRA), Section 9332 (C), entitled “Prohibition Against Billing Non-Assigned Services Which Are Determined to be Medically Unnecessary.” Implementation of this Act was delayed due to lack of administrative funds. However, local Medicare carriers are now enforcing this act, as of April 1988.

The Act provides that medically unnecessary services are those services which are determined not to be covered by Medicare because they are not reasonable and necessary to treat illness or injury.

Reasons for lack of necessity include: unnecessary and inconsistent with generally accepted professional standards (still experimental or under investigation); furnished primarily for the convenience of the patient rather than medically necessary; not furnished at the most appropriate level which can be provided safely and effectively to the patient.

Dr. Jonathan Collin provides services in preventive and natural medicine, wellness medicine, nutrition, vitamin diagnosis and treatment, vitamin injections, and chelation therapy. As such, all of Dr. Collin’s consultations (diagnosis and treatments), vitamin prescriptions, vitamin injections, and chelation treatments are considered “medically unnecessary” per the guidelines specified by Medicare.

It is therefore required that all Medicare patients be duly informed that any services given by Dr. Collin are considered to be medically unnecessary and will not be covered by Medicare. Further, all such services will be payable directly by the patient and may not be submitted to Medicare or any other insurance carrier. Therefore, Medicare patients may not submit any service charge to Medicare for reimbursement. This includes consultations, as well.

Patients who understand this Medicare prohibition, and who wish to receive health care services with Dr. Collin may do so upon signing the following agreement:

I agree not to submit any billing for a “medically unnecessary service” received from Dr. Collin, to Medicare, and further agree to pay for such service myself.

Dated

Signature

Medical History Form

DATE _____

NAME _____ AGE _____
Last First Middle

PRESENT OCCUPATION _____

PREVIOUS OCCUPATIONS _____

NAME OF SPOUSE / AGE _____ CHILDREN/AGES _____

WHY ARE YOU SEEING THE DOCTOR? _____

LIST ALL PRESENT SYMPTOMS, COMPLAINTS, OR ILLNESS, AND LENGTH OF TIME YOU HAVE BEEN AWARE OF THEM _____

HAVE YOU EVER HAD? (Leave blank if “no”. If “yes”, give approximate year it began.)

- | | | |
|----------------------------|-------------------------------|-----------------------------|
| Scarlet Fever | Diabetes | Bursitis |
| Malaria | Cancer | Artery Blockage |
| Rheumatic Fever | Epilepsy | Neuritis |
| Polio | Stroke | Syphilis |
| Meningitis | Asthma | Gonorrhea |
| Mumps | High Blood Pressure | Rectal Disorder |
| Migraine | Nervous Disease | Prostate Trouble |
| Anemia | Mental Disorder | Arthritis |
| Blood Disease | Skin Disease | Rheumatism |
| Heart Trouble..... | Hearing Loss | Varicose Veins |
| Multiple Sclerosis | Sinusitis | Slipped Disc |
| Psoriasis | Pleurisy | Sciatica |
| Cataracts | Stomach Ulcers | Gout |
| Glaucoma | Liver Disease | P.M.S. |
| Thyroid Disorder | Diverticulitis | Yeast Syndrome |
| Bronchitis | Colitis | Chronic Fatigue Syndrome... |
| Emphysema | Kidney Infections | Epstein Barr Virus |
| Gall Bladder Trouble | Kidney Stones | Herpes |
| Diphtheria | Phlebitis | HIV |
| Typhoid | Coronary Artery Disease | Environmental Illness |
| Tuberculosis | Circulation Disorder | Chemical Sensitivity |
| Cirrhosis | Kidney Disease | Depression |
| Pancreatitis | Drug Dependency | Suicide Attempt |
| Alcoholism | Drug Overdose | Addiction Disorder |
| Chemical Poisoning | Biological Poisoning | Covid-19 |

Medical History Form, continued

OTHER SERIOUS ILLNESS _____

LIST ALL OPERATIONS OR SURGERY, AND APPROXIMATE YEAR _____

LIST ANY OTHER HOSPITALIZATIONS – REASON AND YEAR _____

LIST ANY SERIOUS ACCIDENTS – INJURY AND YEAR _____

DATE OF LAST COMPLETE CHECKUP _____ GI SERIES _____

DATE OF LAST CHEST X-RAY _____ BARIUM ENEMA _____

OTHER X-RAYS _____ GALL BLADDER _____

CHECK HOW OFTEN YOU USE THE FOLLOWING (Check which):

	NEVER	OCCASIONALLY	FREQUENTLY	DAILY
ALCOHOL				
LAXATIVES				
SLEEPING PILLS				
ANTACIDS				
ANTIBIOTICS				
ASPIRIN				
PAIN PILLS				

HOW MUCH DO YOU SMOKE? (Packs per day) _____

LIST ALL MEDICINES OR PILLS YOU TAKE (EXCEPT FOR VITAMINS OR SUPPLEMENTS)

(Include prescription, over-the-counter, and 'recreational' drugs)

LIST ANY CHEMICALS, METALS, SPRAYS, FUMES, TO WHICH YOU HAVE BEEN EXPOSED FOR PROLONGED PERIODS

Medical History Form, continued

MALES

Prostate Trouble _____

Swollen Testicles _____

Discharge from penis _____

Venereal disease _____

Trouble with erection or ejaculation _____

FEMALES

Irregular menses _____

Painful menses _____

Cysts or tumors of female organs _____

Vaginal infections _____

Bleeding between periods _____

Pain with intercourse _____

Age menses began _____

Last menstrual period (date) _____

Number of pregnancies _____

Miscarriages _____

Current Weight _____

Height _____

What is the most you have ever weighed? _____ When _____

What is the least you have ever weighed as an adult? _____ When _____

How much weight have you gained or lost in the past year? _____

What times are you most hungry? _____

Do you often find that you can't stop eating? _____

LIST ALL VITAMINS (include strength) AND SUPPLEMENTS YOU TAKE REGULARLY _____

How many hours do you sleep at night? _____

Do you have trouble getting to sleep? _____ Staying asleep? _____

Any other comments about your past or present health _____

List all sports, exercise, or hobbies you engage in regularly _____

Medical History Form, continued

HAVE YOU EVER HAD AN ALLERGY OR BAD REACTION TO:

Penicillin _____	Other medicines _____
Serums _____	or injections _____
Vaccines _____	Other Antibiotics _____
Foods _____	Pollens _____

FAMILY HISTORY:

	IF ALIVE		IF DEAD	
	AGE	ILLNESS	AGE	CAUSE OF DEATH
FATHER				
MOTHER				
SISTER				
BROTHER				

NOTE WHICH MEMBER OF YOUR FAMILY HAS EVER HAD:

Diabetes _____	Migraines _____
High blood pressure _____	Epilepsy _____
Cancer _____	Arthritis _____
Asthma _____	Nervous disorder _____
Ulcers _____	Mental Disorder _____

CHECK IF YOU ARE HAVING ANY OF THE FOLLOWING:

Hives	Burning of urine	Numbness or tingling
Eczema	Weak bladder	Weakness of muscles
Ringling ears	Frequent urinating	Excessive Fatigue
Bleeding gums.....	Shortness of breath	Loss of ambition
Hay fever	Heart murmur	Loss of sex drive
Chronic rash	Vomiting spells	Difficulty concentrating....
Hearing loss	Jaundice	Poor memory
Sore tongue	Easy bruising	Crying spells
Frequent headaches..	Skipped heartbeats	Frequent depressed spells...
Double vision.....	Spitting blood	Frequent suicidal thoughts..
Frequent colds	Diarrhea	Unusual fears
Goiter	Flatulence (gas)	Sexual problems
Chest pains	Bleeding tendency	Irritability
Palpitations	Back trouble	Nervousness
Wheezing	Joint pains	Frequent loneliness
Constipation	Fainting	Nervous breakdown
Heartburn	Dizzy spells	Trouble sleeping
Bloody urine	Spasms or fits	Bad dreams
Sugar in urine	Tremors of hands or feet	Halitosis (bad breath)
Pus in urine	Cold hands or feet	Body odor
Gravel in urine	Hair loss	Skin: Oily or Dry

PLEASE LIST ALL SUPPLEMENTS AND MEDICATIONS
YOU ARE CURRENTLY TAKING, INCLUDING DOSAGE AND FREQUENCY

FOOD ANALYSIS

PLEASE LIST AN EXAMPLE OF YOUR DAILY FOOD AND DRINK INTAKE
Meals, snacks, beverages, including sizes: 8oz chicken, 12oz coffee w/cream

Lab Work/Lab Testing

Please provide copies of recent lab tests from the past two years.

Dr. Collin is looking for lab tests from recent medical examinations and workups.

Additionally, if any tests have been done by naturopathic physicians or integrative clinics examining toxic metals, chemicals, comprehensive hormone profiles, food allergy testing, stool analysis, etc. please provide these reports.

Medical Imaging Reports

Please provide copies of recent imaging reports such as CT scans, MRIs, ultrasounds, etc. from the past two years.

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HIPAA NOTICE –

PLEASE NOTE:

The full 8-page text of the HIPAA policy is provided by this office, and may be requested at any time via the contact information provided below. It may also be accessed or downloaded from our website, but most people do not wish to print out extra pages of a policy that they probably don't even read, so it's not included in this 'short' set of forms.

To obtain a paper or email copy of the policy, or to report concerns, please contact:

JONATHAN COLLIN, M.D.

12911 120TH AVE NE STE A-50

KIRKLAND WA 98034

ATTN: PRIVACY OFFICER

The Privacy Officer can be contacted by telephone at (425) 820-0547

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Notice and Acknowledgement

Acknowledgement

I acknowledge that I have been provided access to the HIPAA - Notice of Privacy Practices.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

Jonathan Collin, M.D.

DrJonathanCollin.com

PORT TOWNSEND OFFICE

911 Tyler Street
Port Townsend WA 98368
(360) 385-4555
Fax (360) 385-0699

KIRKLAND OFFICE

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Consent for Complementary and Alternative Medicine Diagnostics and Treatment

Patient's Full Name _____

I wish to consult with Dr. Jonathan Collin about complementary and alternative medicine in conjunction with conventional medicine to diagnose and treat my medical condition. I am providing Dr. Collin all medical information necessary for diagnosis and treatment.

I understand that complementary and alternative medicine has not yet been established as conventional medicine. However, based on the best available evidence, advised complementary and alternative medicine is appropriate for diagnosis and treatment of my condition in conjunction with conventional diagnosis and treatment.

Dr. Collin agrees to recommend conventional medicine in the diagnosis and treatment of my medical condition. He further advises undertaking all conventional diagnostics and treatments while undertaking complementary and alternative medicine. When conventional medicine has been unsatisfactory in managing my medical condition, Dr. Collin will suggest complementary and alternative medicine for diagnosis and treatment. Just like conventional medicine, complementary and alternative medicine do have medical risks and concerns. Dr. Collin agrees to inform me of such medical risks and concerns.

I understand that at any time I may choose not to proceed with advised complementary and alternative medicine diagnostic testing and treatment. I understand that at any time I may withdraw my consent for care by Dr. Collin.

I have carefully read this consent form and hereby authorize administration of complementary and alternative medicine diagnostics and treatment by Dr. Collin.

Signature of patient _____ **Date** _____

Jonathan Collin, M.D.

DrJonathanCollin.com

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Consent for Treatment and Billing Agreement for Phone Consult Appointment

(signed consent is required to have telephone consultations with Dr. Collin)

Patient's Full Name _____

During the 2021 legislative session, Washington State Substitute House Bill 1196 was passed, outlining terms for billing as it relates to 'Telemedicine', specifically 'audio-only' services. As per the terms of that Bill, we are required to obtain explicit patient consent for billing for telephone appointments.

I agree to consult with Dr. Jonathan Collin by Phone Consult/Telephone to diagnose and treat my medical condition. Further, I understand there is a charge for each appointment and that payment is expected after the consultation.

I have carefully read this consent form, and indicate my agreement with the signature below:

Signature of patient _____ **Date** _____