Jonathan Collin, M.D.

911 Tyler Street
Port Townsend WA 98368 U.S.A.
(360) 385-4555
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Fellow of the American College for the Advancement of Medicine

01 April, 1988

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

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*

INFORMATION FOR PATIENT'S CASE HISTORY

Please Print and Answer All Questions

Patient Name ____
FIRST INITIAL LAST

Birthdate ____________________ Social Security Number _______________________

Single ______ Married ______ Divorced ______ Widowed ______

Home Address ____

Mailing Address ____

Email Address ____

Phone: Home ______________________________ Cell _________________________

Employer ____

Occupation ___________________________ Phone ____________________________

Business Address ____

Spouse/Partner or Parent's Name ____

Employer ____

Occupation ___________________________ Phone ____________________________

Business Address ____

Who should be notified other than spouse in case of emergency?

Name ______________________________________ Relationship _________________

Address ____

Phone __________________________ Email _________________________________

Name of Previous Physician ____

Referred to this office by ____

Date _______________________

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 <u>PRESENT</u> 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 <u>OTHER</u> 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 AGE	ILLNESS		IF DEAD 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 ……………… _________
Eczema …………… _________
Ringing ears ……… _________
Bleeding gums……. _________
Hay fever ………… _________
Chronic rash ……… _________
Hearing loss ……… _________
Sore tongue ………. _________
Frequent headaches.. _________
Double vision……... _________
Frequent colds ……. _________
Goiter …………….. _________
Chest pains ……….. _________
Palpitations ………. _________
Wheezing ………… _________
Constipation ……… _________
Heartburn ………… _________
Bloody urine ……... _________
Sugar in urine ……. _________
Pus in urine ………. _________
Gravel in urine …… _________

Burning of urine ……………… __________
Weak bladder …………………. __________
Frequent urinating …………….. __________
Shortness of breath ……………. __________
Heart murmur …………………. __________
Vomiting spells ……………….. __________
Jaundice ………………………. __________
Easy bruising …………………. __________
Skipped heartbeats ……………. __________
Spitting blood ………………… __________
Diarrhea ………………………. __________
Flatulence (gas) ………………. __________
Bleeding tendency ……………. __________
Back trouble ………………….. __________
Joint pains ……………………. __________
Fainting ………………………. __________
Dizzy spells …………………... __________
Spasms or fits ………………… __________
Tremors of hands or feet ……... __________
Cold hands or feet ……………. __________
Hair loss ……………………… __________

Numbness or tingling ……..__________
Weakness of muscles ……. __________
Excessive Fatigue ……….. __________
Loss of ambition ………… __________
Loss of sex drive ………… __________
Difficulty concentrating…. __________
Poor memory ……………. __________
Crying spells …………….. __________
Frequent depressed spells... __________
Frequent suicidal thoughts.. __________
Unusual fears ……………. __________
Sexual problems ………… __________
Irritability ……………….. __________
Nervousness …………….. __________
Frequent loneliness ……... __________
Nervous breakdown …….. __________
Trouble sleeping ………… __________
Bad dreams ……………… __________
Halitosis (bad breath) …… __________
Body odor ……………….. __________
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, !2oz 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, MRls, 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.
911 TYLER STREET
PORT TOWNSEND WA 98368
ATTN: PRIVACY OFFICER

The Privacy Officer can be contacted by telephone at 360-385-4555

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Notice and Acknowledgement

Acknowledgement

I acknowledge that I have received the 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

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KIRKLAND OFFICE

12911 120th Ave NE Ste A-50
Kirkland WA 98034
(425) 820-0547
Fax (425) 820-0259

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 ____________________

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Consent for Treatment and Billing Agreement for Phone Consult Appointment

(Specific consent is required for having treatment/consult with Dr. Collin by telephone)

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 _____________