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 husband or wife 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 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 …….. _____
Malaria …….. _____
Rheumatic Fever ……..…… _____
Polio ……. _____
Meningitis ……. _____
Mumps …….. _____
Migraine …… _____
Anemia ……. _____
Blood Disease ……..…. _____
Heart Trouble…… _____
Multiple Sclerosis …… _____
Psoriasis ……... _____
Cataracts …….. _____
Glaucoma …… _____
Thyroid Disorder …… _____
Bronchitis …… _____
Emphysema ……..…… _____
Gall Bladder Trouble ……. _____
Diphtheria ……. _____
Typhoid ……..…….. _____
Tuberculosis …… _____
Cirrhosis …….. _____
Pancreatitis …….. _____
Alcoholism …….. _____
Chemical Poisoning …… _____

Diabetes ……...……. _____
Cancer ……. _____
Epilepsy ….…….. _____
Stroke ……..…. _____
Asthma ……..... _____
High Blood Pressure …… _____
Nervous Disease ……..…….. _____
Mental Disorder ……..…. _____
Skin Disease …..……..…. _____
Hearing Loss …… _____
Sinusitis …… _____
Pleurisy ……..…… _____
Stomach Ulcers ……. _____
Liver Disease …… _____
Diverticulitis ……. _____
Colitis …… _____
Kidney Infections ……..… _____
Kidney Stones …… _____
Phlebitis ……. _____
Coronary Artery Disease ….... _____
Circulation Disorder ……... _____
Kidney Disease …….. _____
Drug Dependency …….. _____
Drug Overdose ……... _____
Biological Poisoning …….. _____

Bursitis ……..……..……. _____
Artery Blockage …… _____
Neuritis ……..…… _____
Syphilis …… _____
Gonorrhea …… _____
Rectal Disorder ……. _____
Prostate Trouble …… _____
Arthritis …… _____
Rheumatism ……..……. _____
Varicose Veins ……. _____
Slipped Disc ……. _____
Sciatica ……. _____
Gout …….. _____
P.M.S. …….. _____
Yeast Syndrome …… _____
Chronic Fatigue Syndrome… _____
Epstein Barr Virus …… _____
Herpes ……..…….. _____
HIV ……..……. _____
Environmental Illness ……... _____
Chemical Sensitivity ….……. _____
Depression ……. _____
Suicide Attempt ……. _____
Addiction Disorder ……... _____
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 …… _____
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, MRIs, ultrasounds, etc. from the past two years.

NOTICE OF PRIVACY PRACTICES

For

Jonathan Collin, MD

referred to in this document as "the provider")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The provider may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operation. Your protected health information may be used or disclosed only for these purposes unless the Provider has obtained your authorization, or the use or disclosure is otherwise permitted by the HIPAA Privacy Regulations or State Law. Disclosures of your protected health information for the purposes described in this notice may be made in writing, orally, electronically, or by facsimile.

A. Treatment We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of that provider.

B. Payment Your protected health information will be used, as needed, to obtain payment for the service that we provide. This may include certain communications with your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your insurer to get prior approval for the hospitalization.

We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services, or as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

C. Operations We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the provider and to provide quality care to all patients. Health care operations include such activities as:

- Quality assessment and improvement activities
- Employee review activities
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision
- Accreditation, certification, licensing, or credentialing activities
- Review and auditing, including compliance reviews, medical reviews, legal services, and maintaining compliance programs
- Business management and general administrative activities

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures As part of treatment, payment, and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you
- To contact you to raise funds for the provider or an institutional foundation related to the provider. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer

II. Uses and Disclosures Beyond Treatment, Payment and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal Privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons, including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any Federal, State, or local law.

B. When There Are Risks To Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law
- To report vital events such as birth or death as permitted or required by law
- To conduct public health surveillance, investigations and interventions as permitted or required by law
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs, or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required

C. To Report Abuse, Neglect, Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence. We will make this decision only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. **In Connection With Judicial And Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order in response to a subpoena in some circumstances.

F. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person
- Under certain limited circumstances, when you are the victim of a crime
- To a law enforcement official if the provider has a suspicion that your death was the result of criminal conduct
- In an emergency to report a crime

G. **To Coroners, Funeral Directors, And For Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

H. **For Research Purposes.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In The Event Of A Serious Threat To Health Or Safety.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. **For Specified Government Functions.** In certain circumstances, the Federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions relating to military and veteran's activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation.** The Provider may release your health information to comply with worker's compensation laws or similar programs.

III. Uses And Disclosures Permitted Without Authorization But With Opportunity To Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgement, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses And Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. **The Right To Inspect And Copy Your Protected Health Information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain that protected health information. A "designated record set" contains medical

and billing records and any other records that your physician and the provider uses for making decisions about you.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil criminal, or other administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. <u>The Right To Request A Restriction On Uses And Disclosures Of Your Protected Health Information</u>. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that we not disclose your health information to family members who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The provider is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. <u>The Right To Request To Receive Confidential Communications From Us By Alternative Means Or At An Alternative Location</u>. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. <u>The Right To Have Your Physician Amend Your Protected Health Information</u>. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. <u>The Right To Receive An Accounting</u>. You have the right to request an accounting of certain disclosures of your protected health information made by the provider. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to 14 April 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. <u>The Right To Obtain A Paper Copy Of This Notice</u>. Upon request, we will provide a separate paper copy of this notice, even if you have already received a copy of the notice, or have agreed to accept this notice electronically.

VI. Our Duties

The provider is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the provider changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the provider's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The provider's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer. Information Regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to the Privacy Officer by sending it to:

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.

IX. Effective Date

This Notice is effective 14 April 2003.

Jonathan Collin, M.D.

12911 120TH AVE NE, STE #A-50
KIRKLAND, WA, 98034 U.S.A.
(425) 820-0547
Fax (425) 820-0259

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

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 _____

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

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

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 _____