



**IN ORDER TO CONTROL COSTS, IT IS REQUIRED THAT PAYMENT BE MADE AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE**

Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is my responsibility to pay the deductible amount, co-insurance, or any other balance not paid by my insurance. Even though, as a courtesy, the office has sent an insurance claim, I understand that I will receive a statement of my account if there is an outstanding balance. I further understand the doctor cannot accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim; and that I am responsible for the timely payment of my account and for all delinquency charges resulting from a failure to pay the account promptly. If this account is assigned to an attorney for collection/and or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection.

I understand that Drs. Allen and Carol Stark will not be filing insurance claims to any out-of-network insurance company, and that if I am insured by any of these, I am responsible for paying the full fee at time of service.

Please Initial \_\_\_\_\_

**I UNDERSTAND I WILL BE CHARGED FOR ANY MISSED APPOINTMENTS OR CANCELLATIONS WHERE ONE FULL BUSINESS DAY'S ADVANCE NOTICE HAS NOT BEEN GIVEN.**

Please Initial \_\_\_\_\_

**I UNDERSTAND THE FEE FOR ANY MISSED 30-MINUTE APPT IS \$125**

Please Initial \_\_\_\_\_

**I UNDERSTAND THE FEE FOR ANY MISSED 45-MINUTE APPT IS \$150**

Please Initial \_\_\_\_\_

Patient: \_\_\_\_\_

Date \_\_\_\_\_

Responsible Party \_\_\_\_\_

Date \_\_\_\_\_

**LAKE OSWEGO PSYCHIATRIC ASSOCIATES**  
**Allen L. Stark, M.D.**  
**Carol L. R. Stark, M.D.**  
**4000 Kruse Way Place, Bldg 2, Suite 200**  
**Lake Oswego, Oregon 97035**  
**503.635.9336**

## **NOTICE OF PRIVACY PRACTICES**

**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.**

**WE ARE COMMITTED TO SERVE OUR PATIENTS WITH PROFESSIONALISM AND CARE, BEING SURE AT ALL TIMES TO PROTECT THE PRIVACY AND SECURITY OF ALL PROTECTED HEALTH INFORMATION.**

**DURING THE COURSE OF THE SERVICE OF YOUR INTERESTS IT MAY BE NECESSARY TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS OR BUSINESS ASSOCIATES. THE FOLLOWING ARE EXAMPLES OF INSTANCES WHERE INFORMATION MAY BE SHARED:**

- **OUR BILLING SERVICE**
- **YOUR PRIMARY CARE DOCTOR AND/OR OTHER DOCTORS INVOLVED IN YOUR CARE.**
- **YOUR INSURANCE COMPANY OR WORKER'S COMP COMPANY**
- **YOUR PHARMACY**
- **LABORATORY TESTS**

**WE ARE COMMITTED TO OBEYING ALL FEDERAL, STATE AND LOCAL LAWS AND REGULATIONS REGARDING PRIVACY PRACTICES. IF ANY USES OR DISCLOSURES OTHER THAN THE ONES LISTED ABOVE ARE NEEDED, INFORMATION WILL ONLY BE RELEASED WITH THE WRITTEN AUTHORIZATION OF THE INDIVIDUAL IN QUESTION. THE WRITTEN AUTHORIZATION MAY BE REVOKED AT ANY TIME BY THE INDIVIDUAL, AS PROVIDED FOR BY LAW.**

**IF YOU HAVE ANY QUESTIONS OR COMMENTS REGARDING YOUR PROTECTED HEALTH INFORMATION, FEEL FREE TO CONTACT OUR COMPLIANCE OFFICER AT 503.635.9336**

**I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF PRIVACY PRACTICES.**

SIGNED \_\_\_\_\_  
(PATIENT OR LEGAL GUARDIAN)

DATE \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

PATIENT NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

I/WE HEREBY AUTHORIZE \_\_\_\_\_

NAME/INSTITUTION

STREET ADDRESS

CITY / STATE / ZIP

TELEPHONE NUMBER

FAX NUMBER

AND

LAKE OSWEGO PSYCHIATRIC ASSOCIATES  
ALLEN L. STARK M.D.  
CAROL L.R. STARK M.D.  
4000 KRUSE WAY PLACE, BLDG 2, SUITE 200  
LAKE OSWEGO, OR. 97035  
503.635.9336 PHONE 503.635.5414 FAX

to exchange any information, medical, psychological, scholastic, social which may pertain to my/ our child \_\_\_\_\_ or myself. The question of privacy between the above named parties and the patient is waived. This authority extends to the furnishing of copies of all or any desired parts of the records pertaining to the above mentioned. I specifically authorize the release of information pertaining to psychological and/or psychiatric impairments, drug and/or alcohol abuse, if such is a part of my records. You are all legal liability that may arise from the release of the information requested.

By initialing the spaces below, you state that you understand and agree that the following health information may be disclosed.

- \_\_\_ HISTORY & EVALUATION
- \_\_\_ MEDICATION MANAGEMENT
- \_\_\_ PROGRESS NOTES
- \_\_\_ TEST RESULTS/CONSULTATION
- \_\_\_ AIDS RECORDS OR HIV TESTING
- \_\_\_ GENETIC TESTING
- \_\_\_ OTHER \_\_\_\_\_

This release expires 12 months from date of signature. It may be revoked with written notification at any time except to the extent that action has been taken in reliance on the consent.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT / GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT / GUARDIAN

**LAKE OSWEGO PSYCHIATRIC ASSOCIATES**

**Allen L. Stark, M.D.**

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**Lake Oswego, Oregon 97035**

**(503) 635-9336**

**APPOINTMENT POLICIES**

**Missed Appointments:**

If you are unable to make your scheduled appointment with Dr. Stark, please call at least one full business day before your appointment to reschedule.

IF YOU MISS YOUR SCHEDULED APPOINTMENT OR IF YOU CANCEL WITH LESS THAN A FULL BUSINESS DAY'S NOTICE, YOU WILL BE CHARGED UP TO THE FULL AMOUNT FOR THAT TIME. This is not reimbursable by, nor chargeable to, your insurance.

**Appointment Times:**

Dr. Stark has reserved your appointment time for you. If you are late the appointment time may not be able to be extended and you may be charged for the full session.

If Dr. Stark is late for your appointment only the actual time spent with Dr. Stark will be charged.

**Billing:**

We request that you pay your portion of your fee (co-pay, percentage of total, or full fee) when you arrive for your appointment.

**Prescription Refills:**

Ordinarily, Dr. Stark will write your prescription for new medication, or medication with changes, at the time of your appointment. If you are taking a medication that can be refilled and you do not have any side effects, you may call your pharmacy to request that they fax the refill authorization to our office at 503.635.5414. Please allow five business days for this authorization to be processed.

Please keep this sheet for your records.

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_ Children: \_\_\_\_\_

1. What is the main problem today? \_\_\_\_\_

2. Do you have other concerns today? YES NO

3. Have you ever seen a psychiatrist, psychologist, social worker or counselor before? YES NO

4. Are you taking any medication, prescribed or over the counter? YES NO

5. Do you drink alcohol? How much? \_\_\_\_\_ YES NO  
How often? \_\_\_\_\_

6. Do you drink caffeine? Cups of coffee/day? \_\_\_\_\_ YES NO  
Cola drinks/day? \_\_\_\_\_  
Cups of tea/day? \_\_\_\_\_

7. Do you use tobacco? What form? \_\_\_\_\_ YES NO  
How much? \_\_\_\_\_

8. Do you take recreational drugs? YES NO

9. Are you having problems on the job or at school? YES NO

10. Are you having problems sleeping? (too much, too little) YES NO

11. Has your appetite increased or decreased? YES NO

12. Do you ever make yourself throw up? YES NO

13. Have you been feeling sad? YES NO

14. Have you had thoughts of hurting yourself? YES NO

15. Do you sometimes feel too happy or excited? YES NO

16. Do you sometimes feel you can't control your thoughts or actions? YES NO

17. Are you worried about losing your temper? YES NO

18. Are you afraid you might hurt someone? YES NO

19. Are there times for which you have no memory? YES NO

20. Have you ever had any unusual experiences? YES NO

21. Are you having trouble with your memory? YES NO

22. Do you have trouble concentrating? YES NO

23. Is reading difficult for you? YES NO

24. Do you wish you had either more or less interest in sex? YES NO
25. Do you ever feel there is more than one person inside of you? YES NO
26. Have you ever been physically or verbally abused? YES NO
27. Have you ever been sexually molested? YES NO
28. Are you worried about the behavior of someone close to you? YES NO
29. Are you having problems with your husband/wife, or boyfriend/girlfriend? YES NO
30. Are you having problems with a child? YES NO
31. Are you having problems with a parent or in-law? YES NO
32. Do you have any major physical worries? YES NO

heart                     intestines                     allergies  
 lungs                       kidneys                       cancer  
 stomach                     reproductive organs                     joints  
 vision                       hearing                       handicaps  
 other: \_\_\_\_\_

33. Have you ever been in the hospital? YES NO

When? \_\_\_\_\_

What was the problem? \_\_\_\_\_

34. Are you on a special diet? YES NO

35. Have you consulted a chiropractor, naturopath, or nutritionist? YES NO

36. Do you exercise regularly? YES NO

What form(s): \_\_\_\_\_

How often? \_\_\_\_\_

37. Please indicate if you have a religious or spiritual affiliation: YES NO

\_\_\_\_\_

Are you currently active in this affiliation? YES NO

38. Are you a member of a service or social organization? YES NO

\_\_\_\_\_

39. Is there anything else I should know about you?

\_\_\_\_\_

\_\_\_\_\_