Allen Stark MD **Please Circle One** **Carol Stark MD**

REGISTRATION FORM

ALL AREAS MUST BE COMPLETED **Mark One Area** **New Patient _____** **Update Only _____**

Front and Back MUST BE SIGNED

Primary Care Physician:	PCP Phone # __ __ __ - __ __ __ - __ __ __ __
	PCP Fax # __ __ __ - __ __ __ - __ __ __ __

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Home phone number: __ __ __ - __ __ __ - __ __ __ __		Cell phone number: __ __ __ - __ __ __ - __ __ __ __	
P.O. box:	City:	State:	ZIP Code:		
Occupation: Reason for Visit:	Employer:	Employer phone no.: __ __ __ - __ __ __ - __ __ __ __			
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: __ __ __ - __ __ __ - __ __ __ __		
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:	Employer phone no.: __ __ __ - __ __ __ - __ __ __ __		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance					
Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	Phone # __ __ __ - __ __ __ - __ __ __ __	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other	Phone # __ __ __ - __ __ __ - __ __ __ __	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Allen Stark MD and/or Carol Stark MD or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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.

Patients of Dr. Carol Stark:
I understand that Dr. Carol Stark will not be filing insurance claims to any insurance company she is not on panel with, and that if I am insured by any of these, I am responsible for paying her 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 15-MINUTE APPT IS $100

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_____ DATE_____
(PATIENT OR LEGAL GUARDIAN)

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 hereby released from all legal liability that may arise from the release of the information requested.

DATA REQUESTED

___ HISTORY & EVALUATION
___ DISCHARGE SUMMARY
___ MEDICATION MANAGEMENT
___ PROGRESS NOTES
___ TEST RESULTS/CONSULTATION
___ ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) RECORDS OR HIV 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

_____
WITNESS OFFICE MANAGER

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

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?

_____

_____