M. Jamie McAllister, DO

711 NE Irving Avenue
Bend OR 97701
Phone 541-330-9110
Fax 541-330-9112

Welcome and thank you for choosing Dr. Jamie McAllister for your medical needs. Enclosed you will find the new patient paperwork. Please fill in all information completely and accurately, BEFORE coming to the office and arrive 15 minutes before your scheduled appointment time.

WHAT TO BRING TO MY APPOINTMENT:

* Completed paperwork from Dr. McAllister's office
* Medical Insurance Cards (bring secondary insurance as well if you have 2 insurances)
* List of current medications
* Auto Insurance letter with claim number and billing information (if this visit is related to an auto accident)

INSURANCE/BILLING INFORMATION:

Payment options offered by this office:

1) Payment in full by cash, check, Visa or Mastercard on the date of service. We will extend a 20% discount to cash patients who pay their visit in full the day of the service.

2) Use of your medical insurance, with payment of your co-pay at the time of service. Balances billed to patient are due in 30 days.

3) If you do not have your insurance card, you can either reschedule your appointment or pay for your visit in full at the time services are rendered. We will supply you with the necessary information to submit the claim to your insurance company.

If you have any questions regarding your insurance, please contact your insurance company PRIOR to your initial visit.

Patients should remember that professional service are rendered to a person, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the doctor. We will help in every way we can by filing your claim and answering your questions. Patients are encouraged to stay in contact with their insurance company regarding the claim processing or other questions about insurance reimbursement.

***** We have a 48 hour cancellation policy for new patients. If for any reason this appointment should conflict with your schedule, please call us to reschedule as soon as possible. If you fail to cancel your appointment 48 hours before or do not show up at your appointed time YOU WILL NOT BE RESCHEDULED*****

M. Jamie McAllister, DO

Adult & Adolescent Family Medicine

Addictive Prescription Policy

Dr. McAllister is a Family Practice doctor who also has a sub-specialty in Addiction Medicine. It is our office policy and philosophy that the following medications are generally not prescribed, due to their addictive nature:

Ambien/Zolpidem	Ativan	Butalbital
Dalmane	Darvocet	Darvon
Demerol	Dilaudid	Duragesic
Esgic	Fioricet	Fiorinal
Halcion	Hydrocodone	Klonopin/Clonazapam
Librium	Lortab	Lunesta
Morphine	MS Contin	Norco
Oxycodone	Oxycontin	Restoril/Rhyzolt
Percocet	Percodan	Phenobarbital
Serax	Soma	Sonata
Tamezepam	Tranxene	Tylenol w/ codeine
Tylox	Ultram/Tramadol	Ultracet
Vicodin	Valium	Xanax

**As new medications are created, this list may not be complete.

If there is a medication you take that you think she may not prescribe, call our office and check before your appointment. In general, this list of medications is used to treat conditions such as: chronic pain, anxiety, insomnia, and attention deficit disorder. In most cases, there are alternative methods of treating these conditions, different medications that can be used, or underlying problems that can be diagnosed and treated to alleviate the problem.

Situations in your health may arise where such medications may be warranted and prescribed by Dr. McAllister, however they will not be prescribed long term.

If you have been taking any of these medications on a regular basis, and Dr. McAllister not prescribing them is an issue, please call our office as soon as possible to discuss it prior to your appointment time.

_____ _____ _____

Print name Signature Date

PATIENT INFORMATION

Last First MI Soc.Sec,.#

Street Address City State Zip

Mailing Address (if different from street address) City State Zip

Date of Birth Age Gender Marital Status

Home Phone Cell Phone Work Phone

Place of Employment Occupation

Emergency Contact (Name) Phone Number Relationship

I give permission to discuss my medical condition with this person [ ] Yes [ ] No

Insurance Information/Responsible Party
Please present your insurance card to the receptionist when you arrive at the clinic. Insurance will be billed as a courtesy. In addition to providing your card, please complete information below.

Primary
Insured/Subscriber_____
Last First MI DOB
Subscriber
Employer_____

Secondary
Insured/Subscriber_____
Last First MI DOB
Subscriber
Employer_____

- I have read and understand the Financial Policy.
- I hereby authorize M. Jamie McAllister D.O. to release information necessary to secure payment of benefits. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount due on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including collections and or attorney fees.

Signature_____**Guardian if minor**_____

Date_____

M. Jamie McAllister D.O.
711 NE Irving
Bend , Or 97701

Men's Health History

Today's Date: _____

Name: _____Date of Birth: _____ Age: _____

Home Phone: _____ Alternate/Cell Phone: _____Work Phone: _____

Medications you are currently taking:

_____
_____
_____
_____
_____

Reason for visit:

_____
_____
_____
_____
_____

Other concerns about your health? Please explain:

_____
_____
_____
_____
_____

Date of last cholesterol check: _____ Normal? Yes No

Date of last Prostate Exam: _____ Normal? Yes No

Date of last PSA: _____ Normal? Yes No

Date of last Colonoscopy: _____ Normal? Yes No

Is there family history of heart disease? Yes No If yes, who?

_____

Are you taking Vitamin D? Yes No

M. Jamie McAllister, DO

Adult & Adolescent Family Medicine

Date: _____

Patient History

Name _____ Age _____ Occupation _____

Briefly tell me about yourself; where you were raised, your job, family hobbies:

Family History of Medical Problems:

	Age (living)	Age at death	Medical Problems:
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister (s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Current Medications you are taking: _____

_____

_____

Allergies to medications: _____

Habits:

Do you smoke? No Yes How many per day? _____ How many years? ____
Did you smoke? No Yes How many per day? _____ How many years? ____
Do you drink alcohol? No Yes
If yes, per day I drink _____ beers _____ glasses of wine _____ drinks of hard liquor
Have you ever had a problem with drugs or alcohol or been in treatment? No Yes
Explain:

Patient History Page 2

List Recent and past history of major medical and or psychiatric problems (include approximate dates):

List past history of all surgeries (include approximate dates):

List specific concerns you currently have about your physical and or mental health:

ACKNOWLEDGEMENT AND CONSENT

I understand that M. Jamie McAllister, DO Adult & Family Medicine (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area or other visible area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices if I had requested it.

Patient Signature:_____ Date: _____

OR

Patient Representative Signature: _____ Date: _____

Description of Representative's Authority: _____

FINANCIAL POLICY

INSURANCE BILLING

- **Your health insurance is a contract between you and your insurance company. Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions regarding your policy. We participate in most insurance plans. Due to the number of plans we cannot provide individual policy benefit information. We submit claims as a courtesy, in order to do so, we must have a copy of your current insurance card. If we do not receive a copy of your insurance card, we will request payment in full at the time of service.
- If you are not insured by a plan we do business with, payment in full is expected at time of service. We do extend a 20% discount to uninsured patients. (This discount is not applicable to patients who have high deductible policies as they will automatically receive a discount based on our contracted rate with their insurance company.)
- **Co-payments and deductibles -** All co-payments and deductibles must be paid at the time of service. <u>This arrangement is part of your contract with your insurance company</u>. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.
- **Non covered services –** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.
- **Claims submission –** We will submit your claims and assist in any way we reasonably can to help get claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.**
- **Non payment –** If your account is over 90 days past due, you will receive notice stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if your balance remains unpaid we will refer your account to a collection agency and you will be discharged from the practice. Accounts that are referred to collections are subject to a collection fee and/or attorney fees.
- **Missed appointments –** Our policy is to charge for missed appointments not canceled within 24 hours of appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointments. **New patients who miss their initial appointment will not be rescheduled.**

I have read and understand the payment policy:

Patient/Responsible party_____
Date_____