Eau Claire Location:

3802 W Oakwood Mall Drive * Telephone 715.839.9280 * Fax 715.839.9348

Chippewa Falls Location:

2829 County Highway I, Suite 2A * Telephone 715.839.9280 * Fax 715.726.2087

OFFICE VISIT CHECKLIST

☐ Bring your insurance cards with you to every appointment, everytime.

☐ It is your responsibility to understand your insurance coverage.
- Which physicians are covered in your plan?
- What are your co-pay amounts for office visits?
  - You may pay your co-pay at the time of your visit.
  - Cash, check or credit card is accepted.

☐ Questions about your insurance?
- Call your employer's Human Resource Department or the telephone number on your insurance card.
- Every health care plan varies based on your employer.

☐ Review your pharmacy benefits.
- Do you need a 30 day or 90 day prescription?
- Should you have generic versus brand name medications.
- What pharmacies can you use?
- Is the medication on the formulary?
- Do you need prior authorization?

OakLeaf CLINICS
EAU CLAIRE MEDICAL CLINIC

PATIENT INFORMATION/ Health History Form

Patient's Legal Name (Last)_____(First)_____(MI)_____

Preferred First Name: _____ Maiden Name/Previous Names: _____

SSN_____ Birthdate_____ □ Male □ Female

Address _____City_____ State ____ Zip_____

Home Phone#_____ Cell Phone#_____ Work Phone#_____

Patient's Employer_____ Occupation: _____

Emergency Contact Name: _____ Phone Number _____

Email Address: _____ Would you like information on the patient portal? □ Yes □ No

Appointment Reminders: □ Telephone Call □ Text Message *(Message & data rates may apply)* □ Patient Portal/Email

Please Check all that apply: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Race: □ White □ Asian □ Native Hawaiian □ Other Pacific Islander □ African American □ American Indian □ Alaska Native

Language: □ English □ Spanish □ Hmong □ Other_____ **Ethnicity**: □ Not Hispanic/Latino □ Hispanic/Latino

Legal Guardian/Parent's Name (If applicable) _____ Phone # _____

Legal Guardian/Parent's Name (If applicable) _____ Phone # _____

Are you a Student? Name of school/college: _____

Who is your Primary Care Provider? _____ Whom may we thank for referring you? _____

FAMILY INFORMATION: Name and Age

Spouse:

Children:

INSURANCE INFORMATION/RESPONSIBLE PARTY: *Required, unless you are self-pay*

Primary Insurance _____ID #_____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

Secondary Insurance _____ID # _____Group #_____

Policy Holder_____ Employer_____Work Phone_____

Relationship to Patient _____Birthdate _____SSN_____

OakLeaf CLINICS
EAU CLAIRE MEDICAL CLINIC

PAST MEDICAL HISTORY: *Please check all that apply*

	Arthritis		Kidney Disease/Problems		Anemia
	Diabetes		Radiation Therapy		Chemotherapy
	Blood Clots		Rheumatic Fever		Jaundice (Yellowing of Skin)
	Heart Attack/Chest Pain		Tuberculosis		Sinus Problems
	Stroke		Bleeding Tendency		Pneumonia
	Transfusions		Bronchitis		Asthma/Wheezing
	Thyroid Disease/Goiter		High Blood Pressure		Emphysema
	COPD		Congestive Heart Disease		Nervous Breakdown
	Chicken Pox or Immunization		High Cholesterol		Depression
	Cancer		Valve Replacement		Joint Replacement
	Heart Murmur		Difficulty Sleeping		Headaches
	Excessive Fatigue		Weight Loss/Gain		Moles that Have Changed
	Heartburn		Constipation		Diarrhea
	Black Tarry Stools		Recurrent Stomach Pain		Bladder Control/Leak
	Vaginal Discharge (Itching/Burning)		Difficulty Swallowing		Sores in the Mouth
	Long-Term Back Pain		Swollen Painful Joints		Swelling of Feet/Ankles

Please describe any other medical problems not listed above:

_____

_____

_____

PREVIOUS HOSPITALIZATIONS	**Year**	**PREVIOUS SURGERIES**	**Year**

FAMILY MEDICAL HISTORY

Family Member	Age	Living	Major Illness
Father			
Mother			
Brothers			
Sisters			

OakLeaf CLINICS
EAU CLAIRE MEDICAL CLINIC

IMMEDIATE FAMILY WITH ANY OF THE FOLLOWING:

	Cancer		Alcoholism
	Goiters		Allergy
	Kidney Disease		Bleeding Tendency
	Tuberculosis		Asthma

ALLERGIES	**REACTION**
Non-Drug	
Drug	
Food/Seafood	

Please list all current medications and supplements:

MEDICATION NAME	**DOSE**	**FREQUENCY**

PROCEDURES	**MONTH/YEAR**
Colonoscopy	
Mammogram	
PAP	
Bone Density	
PSA	

IMMUNIZATION	**YEAR**
Tetanus	
Flu Vaccine	
Pneumonia	
HPV	
Hepatitis B	

Check all that apply:

	Illegal Drugs		Regularly Exercise		Special Diet
	Good Support Group		Wear Seat Belts/Helmets		Alcohol Use
	Caffeine Consumption		Smoker		Chewing Tobacco

OakLeaf CLINICS
EAU CLAIRE MEDICAL CLINIC

WOMEN'S HEALTH ONLY:

Medical Problems	No	Yes	Have Now	In the Past
Abnormal Pap Smear				
Procedures on your cervix				
Abnormal Bleeding				
Breast, uterine, ovarian or colon cancer				
Surgery on uterus or C-Section				
Breast cysts, lumps, biopsies				
Nipple discharge				
Fibroids				
Night sweats, hot flashes				
Pain with intercourse				
Recurrent vaginal infections				
Unable to get pregnant after trying				
Uterine abnormalities				
Verbal, physical or sexual abuse				
History of Sexually Transmitted Diseases:				
Chlamydia				
Warts (HPV)				
Gonorrhea				
Syphilis				
Herpes				
HIV/AIDS				

Please answer the following:

What was the first day of your last menstrual period?	
How old were you when you had your first period?	
How often do you get your period?	
How many days do you menstruate?	
Are your periods heavy or painful?	
When was your last pap smear?	
How many times have you been pregnant?	
How many children do you have?	
How many vaginal deliveries?	
How many C-Sections?	
How many miscarriages?	
How many elective abortions?	
How do you currently prevent pregnancy?	
How long have you been with your current partner?	

FAMILY SHARED INFORMATION

Patient Name: _____ Date of Birth: ___/___/___

I hereby consent that my healthcare information may be shared both verbally and by mail with the following individuals:

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Name:	Relationship:
Telephone Number:	

Signature: _____ **Date: ___/___/___**

WRITTEN ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge that I have received the written Notice
Print Name

of Privacy Practices from Oakleaf Clinics, S.C. as a new patient and annually thereafter.

_____ Date: ___/___/___
Patient or Personal Representative Signature

_____
(Personal Representative, describe relationship to patient.)

The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

Acknowledgement was unable to be obtained. Reason: _____

_____

_____

_____

Employee Signature: _____ Date: ___/___/___

PATIENT FINANCIAL POLICY

Thank you for choosing OakLeaf Clinics as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. *Please understand that payment for services is part of that relationship*. Please ask if you have any questions about our fees, our policies or your responsibilities.

CO-PAYMENT OPTIONS

Co-Payment is due at the time of service. Your insurance company requires that we collect all co-pays at the time of check-in. We accept cash, check, credit and debit cards. The amount of your co-pay may be listed on the front of your insurance card. If not listed, please contact your insurance provider. **Waiver of co-pays may constitute fraud under State and Federal law.**

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the clinic does not participate or patients without an insurance card on file with us. Self-pay accounts will be discounted 15.0%. Payment will be collected in full at the time of check-in. The balance of your account, including all ancillary services (lab, imaging, etc), will be billed to you following your visit. We are willing to work with you on a payment arrangement for the balance of your account if necessary. It is never our intention to cause financial hardship on our patients, only to provide them with the best care possible with the least amount of stress.

INSURANCE

You will need to present your insurance card at each visit. **It is your responsibility to supply us with all necessary insurance information at the time of your appointment.** Please contact your insurance company or employer if you have questions about covered services.

Insurance is a contract between you and your insurance company(s). In order to properly bill your insurance company(s), we require that you disclose all insurance information including primary, secondary and any other relevant insurances. We participate in most major insurance plans; however it is your responsibility to make sure the physician you are seeing is listed with your insurance plan as a participating provider. The insurance company will make final determination of your eligibility and benefits.

If your insurance company is not contracted with us, you agree to pay any portion of charges not covered by insurance. If we are out of network for your insurance company and your insurance company pays you directly, you are responsible for payment and agree to forward payment to us.

PATIENT RESPONSIBILITY

It is your responsibility to understand your benefits and coverage and to obtain proper certification when needed. It is also your responsibility to pay any deductible, co-insurance or any other balance not paid by insurance.

DENIED CLAIMS

Our office will provide all necessary medical information to your insurance carrier to properly process your claim. In the event your claim is denied for any reason, the balance becomes your responsibility and payment is expected at that time.

NO SHOW AND CANCELLATION POLICY

We require 24 hour notice if you are unable to keep a previously scheduled appointment. In the event you do not provide 24 hour notice or do not show up for your appointment, we reserve the right to charge a $25 fee to your account.

RETURNED CHECKS

Any account where a check is returned by our bank with NSF (non-sufficient funds) designation will be charged a $50 NSF fee. This fee, as well as the account balance, is due upon receipt. We reserve the right to only accept payment in the future on your account with cash, credit or debit cards.

PAYMENT PLAN OPTIONS

Patients who have outstanding balances as the result of Deductibles, Co-Insurance or who are self-insured can work with our staff to set up a payment plan. We expect that 10% of your outstanding balance or a minimum of $25 will be paid each month and that the balance will be paid in full in no longer than 12 months. Oakleaf Clinics, SC will not waive, fail to collect, or discount co-payments, co-insurance, deductibles or other patient financial responsibility in accordance with State and Federal law, as well as participating agreements with payers. Additional options may be available through our Patient Payment Assistance Program – income guidelines apply.

PATIENT PAYMENT ASSISTANCE PROGRAM/HARDSHIP

OakLeaf Clinics, SC does offer financial assistance to those who qualify. See the separate Patient Payment Assistance Program for more information.

PATIENT AUTHORIZATION – ASSIGNMENT AND RELEASE

I have read, understand, agree to and will abide by the Financial Policy outlined above. I understand that I am financially responsible for all services and charges whether or not covered by my insurance.

I hereby assign all medical and/or surgical benefits to include major medical to which I am entitled including Medicare, Private Insurance and other health plans to OakLeaf Clinics, SC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____

Print Patient Name

_____ ____/____/_____

Patient or Personal Representative Signature Date

_____

(Personal Representative, describe relationship to patient.)

*Patient Signature on File for **Medicare** Claims and any other insurance, including **Medigap** Insurance.*

I request that payment of authorized Medicare benefits and/or Insurance benefits be made either to me or on my behalf to: OakLeaf Clinics, SC. For any services furnished to me by that provider. I authorize any hold of medical information about me to release to the CMS Administration to determine these benefits or the benefits payable for related services.

Signed:_____Date: ___/___/___

OakLeaf CLINICS
EAU CLAIRE MEDICAL CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

_____ _____
Patient Name/Previous Name(s) *Date of Birth*

_____ _____
Street Address *City, State, Zip Code*

AUTHORIZES FROM:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Code

RELEASE OF PROTECTED INFORMATION TO:

Eau Claire Medical Clinic
3802 W. Oakwood Mall Drive
Eau Claire, WI 54701
Phone: 715-839-9280
Fax: 715-839-9348

For the following dates: ___/___/___ to ___/___/___

INFORMATION TO BE RELEASED:

_____Medical History, Examination, Reports _____ Surgical Reports _____ Immunizations _____ Treatment or Tests

_____Hospital Records/Reports _____Radiology Reports _____ Laboratory Reports _____Consultations

_____ Other _____

In compliance with Wisconsin Statutes, to release privileged information; Please release records pertaining to:

_____Mental Health _____Developmental Disabilities _____ Alcoholism

_____HIV (AIDS) _____Sexually Transmitted Disease _____Drug Abuse

PURPOSE OF DISCLOSURE:

_____Further Medical Treatment _____ Legal Investigation/Action _____Personal

_____Insurance Eligibility/Benefits _____Changing Physicians _____Other _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Oakleaf Clinic, SC. Right to Receive Copy of this Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I may be provided with a signed copy of the form. Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Oakleaf Clinics, SC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that a person(s) and/or organization(s) listed above have already made in reference to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six months from the date signed.

I understand the content of this authorization form and confirm that it accurately reflects my wishes.

_____ _____
Signature of Patient or Legal Representative/Relationship *Date*

_____
Witness