Eau Claire Location:

3802 W Oakwood Mall Drive * Telephone 715.839.9280 * Fax 715.839.9348

Chippewa Falls Location:

855 Lakeland Drive * 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?

Pediatric Health History *age 12 and under*

Child's Name: ____Today's Date: ______________________

Child's Birthdate: ______________ Female Male Name of School & Grade ________________________

Address: ____
(Street) (City) (State) (Zip Code)

Emergency Contact Name: __________________________________ Phone: ___________________________

Relationship to child: ____

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

Language: English • Spanish • Hmong • Other • Decline **Ethnicity:** Not Hispanic/Latino • Hispanic/Latino • Decline

Parent Information

Father's Name: ____ Date of Birth: ___________________
Occupation: ______________________________ Place of Employment: ______________________________
Home phone: ______________________________ Work phone: _____________________________________

Mother's Name: ____ Date of Birth: __________________
Occupation: ______________________________ Place of Employment: ______________________________
Home phone: ______________________________ Work phone: _____________________________________

Are Parents: ☐ Married ☐ Divorced ☐ Separated

Who else lives in the child's home? ____

Please list the names and relationships of anyone else involved in the child's care: ____________________________

____

Family History

Names and birthdates of siblings: ____

____

Family Health History: Does anyone in your family suffer from?

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Alcoholism/Drug abuse				High Blood Pressure			
Allergies				High Cholesterol			
Asthma/Hay fever/Eczema				Inherited/Genetic Disease			
Birth Defects				Kidney Disease			
Bleeding/Clotting Issues				Psychiatric Disorders			
Cancer				Seizures			
Depression				Stroke/Heart Disease			
Diabetes				Thyroid Disorder			

Newborn/Infant History

(Please fill out if child is less than 5 years of age)

Birth weight: _______________ Method of Delivery: ☐ Vaginal ☐ C-Section ☐ Forceps/Vacuum

Length of pregnancy: ___________weeks Feeding: ☐ Breast ☐ Bottle ☐ Both

Problems during pregnancy or delivery: ____

While in the hospital, did the child have any of the following?

Condition	Y	N	Condition	Y	N
Jaundice			Infection		
Poor Feeding			Breathing Concerns		

Other concerns during hospital stay:

____

____

Did mother and child leave the hospital together? If no, please explain: ______________________________

____

How many hours per night does your child sleep? ____________Naps? (Number & Length) ______________

Does your child have any sleep problems? If yes, explain: ____________________________________

Has your child been immunized? ☐ Yes ☐ No If yes, in WI? ☐ Yes ☐ No Other state? _____________

Has your child been seen by a dentist? Yes ☐ No ☐ If yes, date of last visit_______________________

Does anyone in the home smoke? Yes ☐ No ☐ Has your child been exposed to lead? Yes ☐ No ☐

Health History

Please list all current medications and supplements:

MEDICATION NAME	DOSE	FREQUENCY

Please list any allergies and reactions:

ALLERGY	**REACTION**
Non-Drug:	
Drug:	
Food/Seafood:	

Did this child have, or does this child now have any of the following?

Condition	Y	N	Date	Condition	Y	N	Date
Frequent Colds/Infections				Chronic Cough			
Easy bruising or bleeding				Wheezing or Asthma			
Loss of consciousness				Poor appetite			
Head Injury				Weight loss			
Seizure or convulsion				Heart murmur			
Frequent headaches				Bloody stool			
Eye problems				Blood in urine			
Recurrent ear infections				Swollen joints			
Hearing problems				Frequent falling			
Constipation				Dental cavities			
Chronic vomiting or diarrhea				Skin problems			
Frequent stomach aches				Ingestion of poison			
Bladder/Kidney problem				Chicken pox			
Meningitis				Whooping cough			

Please list any previous hospitalizations or surgeries:

PREVIOUS HOSPITALIZATIONS	PREVIOUS SURGERIES

Concerns about your child: ☐ Alcohol use ☐ Tobacco use ☐ Sexual Activity ☐ Aggressive behavior

Is violence at home a concern? ☐ Yes ☐ No If yes, explain: ____

Girls only: Age of first menstrual period? ____

Current grade? ______________________________ Name of school? ____

Sports/exercise. Type? _____________________________________ How often/minutes per day? ____________________

How many hours per day does your child do the following?

Watch TV _______________________Computer ______________________ Video Games ___________________________

Any other major illness? If yes, explain: ____

____

Thank you for choosing our office, we look forward to caring for your child.

AUTHORIZATION FOR TREATMENT of a MINOR

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

I hereby authorize ____ to bring the above named
(Name/Relationship to Patient)

individual to an OakLeaf Clinics, SC provider for care.

This authorization is in effect until: ___/___/___

Parent/Guardian Name: ____
(Please Print)

Parent/Guardian 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: ___/___/___

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:

OakLeaf Clinics
Phone: 715-839-9280
Fax: 715-552-3791 for Eau Claire office
Fax: 715-720-0747 for Chippewa Falls

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