



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?



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.)