OAKVIEW
DERMATOLOGY

PATIENT INTAKE FORM

Patient Name: _____

Date of Birth: _____

Phone Number: _____

1. Who is your Primary Care Provider (General Practitioner)? _____
    a. City, State: _____
2. Did a physician refer you to our office for today's appointment? Yes or No
    a. By whom were you referred? _____
3. Alcohol history: Do you consume alcohol? Yes or No
    a. Do you generally consume more than 5 drinks per sitting? Yes or No
4. Smoking history: (please circle one) Current Former Never
5. Did you receive the flu vaccination before/during this past flu season? Yes or No
6. Have you ever received the pneumonia vaccine? Yes or No
7. Do you have a living will? Yes or No

    If yes, do you have a Power of Attorney (POA)? Yes or No

    If yes, name of your POA? _____

8. Do we have your permission to import your pharmacy records to help coordinate your care? Yes or No

    Preferred Local Pharmacy _____

Office Use Only:

- **Visit Date:**
- **History Taken By:**

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Patient Information

Name *(last, first middle)*:_____ Birthday: _____ SSN: _____ Sex: _____

Address: _____

Home Phone #: _____ Cell Phone #: _____ Language: _____

Can we leave a message if we are unable to reach you: -Select- || Smoker: -Select- || Veteran: -Select-

Email Address: _____ Primary Care Doctor: _____

Ethnicity *(select all that apply):* ○ Hispanic or Latino ○ Non-Hispanic or Latino ○ Unknown ○ Other: _____

Race *(select all that apply):* ○ White/Caucasian ○ Black/African American ● Asian ○ Native Hawaiian/Other

○ Pacific Islander ○ American Indian/Alaska Native ○ Other: _____

Receipt of Notice of Financial & Privacy Practices

I am a **PATIENT/PARENT OR LEGAL GUARDIAN** (please circle one) of Oakview Dermatology. I hereby acknowledge receipt of Oakview Dermatology's Notice of Financial & Privacy Practices.

Patient's initials: _____ **-- OR --** Parent or legal guardian initial: _____

Receipt of HIPAA Guideline

Oakview Dermatology adheres to the following HIPAA guidelines set forth by the United States Department of Health and Human Services and the Office for Civil Rights:

Patient Consent:

The patient listed above or the legal representative for the patient listed above understands:

- Reminders of upcoming scheduled appointment may be left on an answering machine or with a family member.
- Protected Health Information (PHI) may be disclosed or used for treatment, payment, or health care operations
- Oakview Dermatology has a "Notice of Privacy Practice" that can be reviewed by the patient at any time.
- Notification regarding the availability of pathology or laboratory results may be left on an answering machine or with a family member BUT that actual result WILL NEVER be left to anyone other than the patient or family member(s) listed below.
- All of the policies listed on the Notice of Financial and Privacy Practice form will adhere to them when applicable.

Authorization for Disclosure of Medical Records: I authorize the disclosure of any of my medical records to the following individual(s)

1. _____ _____ _____
   Name Relationship Phone
2. _____ _____ _____
   Name Relationship Phone

Minors and POA

Is this patient under the age of 18? -Select- ||Does this patient have a POA? -Select- || if yes to either of these please fill out the section below.

Any services not covered by the patient's insurance will become the signee's responsibility for full payment of services rendered by Oakview Dermatology, LLC.

Name of Responsible Party: _____ Birthday: _____ SSN: _____

Address: _____ Relationship: _____

_____ _____

Signature of patient or responsible party Date

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FINANCIAL POLICY

Thank you for choosing Oakview Dermatology for your skin care needs. We are dedicated to providing the best possible care and service for you. We realize the challenges with health care costs today and we do our best to inform you of your personal and financial responsibility.

1. **Insurance:** your visit is filed with your insurance carrier. It is the responsibility of the patient to provide accurate insurance and personal information. If your insurance requires a referral, it is your responsibility to provide the referral prior to your visit. You will be responsible at the time of service for the payment of copays and any past due balances.

2. **Self-Pay:** Payment is expected in full at the time of service.

3. **Cosmetic Procedures:** A deposit may be required for some procedures. Additionally, this deposit may be forfeited if you no show without the appropriate 24-hour notice. All payments for cosmetic services and/or products must be made using cash or credit card. Personal checks are not accepted for cosmetic procedures or products.

4. **Cancellations and Missed Appointments:** Cancellations and changes to appointment should be made as soon as possible. If you fail to show up for your assigned appointment without canceling 24 hours in advance:

    - A $45 no-show fee will be charged for general appointments
    - A $200 no-show fee will be charged for missed surgical or cosmetic appointments

5. **Request for medical records/forms:** Releasing of medical records is available at a fee dependent upon chart volume. Medical records may be sent to another provider at no charge. Insurance, disability, applications forms, etc. will be a minimum charge of $10 payable in advance.

6. **Methods of payment accept are:** Cash, Visa, MasterCard, Amex, Discover and personal checks (not cosmetic) with proper identification are accepted. A $30 overdraft charge will be added to any insufficient funds amount on any returned check.

7. **Auto Pay and Credit Card on File:** Oakview Dermatology securely stores an updated credit card on file for all patients. This information is stored securely with the same HIPAA-compliant software that protects your confidential medical information. Should you have a balance after your visit, after we received your insurance response, you will receive a statement from Oakview Dermatology and be processed for the remaining balance 10 days after the statement is issued.

8. **Pathology and Labs:** A separate charge will be applied for labs and pathology service if your office requires a biopsy or bloodwork. We use PathGroup as our pathology lab and urge you to check with your insurance company about your coverage. PathGroup will process all claims as in-network. Any amount not covered by your insurance is your responsibility.

By signing this form you authorize Oakview Dermatology to bill your insurance and card on file as described above. You agree that you have read, understand and abide by our stated financial policies. I agree to pay Oakview Dermatology's charges for any healthcare services provided to me or my dependent(s), as well as any co-pays, deductibles, co-insurances, or amounts for services not covered.

Print Patient's Name _____ Date of Birth _____

Signature of patient or responsible party _____ Today's Date _____