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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Dear Patient:

Thank you for choosing Oakview Dermatology to provide your dermatologic medical care. Our top priority is providing you with the highest quality medical care, and we believe that communication and understanding are the cornerstones of a good physician-patient relationship.

To provide you with an understanding of what you can expect financially at the time of your visit, we need to communicate our Financial Policy in writing.

Patient Responsibilities:
There are more than 1,000 health plans with which we work. Each plan is unique, and we cannot be responsible for knowing the details of each individual plan. **It is your responsibility, as a subscriber and as a patient, to:**

- **Determine if we are a participating provider with your specific plan.**
- **Know the requirements and limitations of your specific plan.**
- **Present your current insurance card at each visit.**
- **Pay any Co-Payments, Co-Insurance, and/or unpaid deductibles at the time of service.**

Payment for Services:

- Please be prepared to pay for services at the time of each visit.
- If you do not have insurance, or if you have insurance with a plan with which we do not participate, you will need to pay in full at time of service.
  We will provide a cash discount in these instances.

If We Participate with Your Insurance Plan:

- We will bill your plan directly, assuming we can verify your coverage
- You may still have to pay a portion of the bill even with insurance coverage (Co-payments and Deductibles).
- If you have an unpaid balance, you will be asked to pay this at the time of your appointment.
- Any overpayments will be refunded to you via the same method you used for payment

How Our Arrival and Check-In Process Works:

- All demographic information will be verified and updated by our front desk staff when you arrive.
- We will need a copy of your insurance card at EVERY visit.
- We must collect Co-Pays and patient Co-Insurance directly from you at the time of service.
- You may be asked to reschedule if you are not willing to pay your Insurance Co-Pay.
- It is very important that you share any new insurance cards that you may receive from your insurance company.

If Your Insurance Requires a Referral:

- In these cases, insurance will not pay for your visit if there is no referral on file.
- To ensure a smooth appointment, please bring the referral with you or verify ahead of time that the referral has been received.
- We may need to reschedule your appointment if we do not have your referral and one is required.
- Payment will be the patient's responsibility if a referral is needed but not obtained.

Secondary Insurance:

- Your insurance card will be copied so that we may verify your coverage.
- We will submit one (1) claim with your secondary carrier if we are able to verify your coverage.
- It is important to be aware that in some cases, the secondary policy will not pay additional benefits. As a result, you may still have a personal balance to settle, even if you have two carriers.
- We will transfer the balance on the account to you if we do not receive payment from your secondary carrier within a reasonable timeframe (45 days).
- In addition, we do not file tertiary insurances.

Coding and Billing:

- It is important to note that we will only code and file claims for procedures or diagnoses that were encountered and documented appropriately within the medical record.
- It is inappropriate and considered fraudulent to request that a diagnosis be changed solely for the purpose of obtaining reimbursement from an insurance company.

Medical Services Not Covered Under Your Plan:

- We will collect payment in full at the time of service.
- There are many procedures in dermatology that are considered Not Medically Necessary by your insurance, we will try to discuss these items with you when they come up so that you may decide as to whether you would like them treated.

Out of Network Plans:

- We are happy to provide you with a claim form from our office for your submission to insurance upon your request.

Questions about your Insurance Plan:

- If you have any questions about basic insurance, we are always happy to help. If you have questions about your individual coverage, you should contact your insurance company's Member Services Department (the number is on the back of your insurance card, or you can contact your employer's Benefits Office).

Payment Plans:

- A payment arrangement will be necessary if you are unable to pay in full
- Your financial situation can be assessed by our billing staff.
- Payment plans require electronic payment guarantee (automatic credit card processing or scheduled debits from your bank account).
- Nonpayment of a payment plan will result in referral to a collection agency.

Delinquent Accounts:

If you fail to pay your bill in a reasonable time frame:

- Your outstanding balance will be referred to a collection agency and a $10.00 fee will be assessed Additionally; this will result in Oakview Dermatology terminating the patient-physician relationship.

Termination of Physician/Patient Relationship: A physician is not compelled to treat every patient who requests treatment. According to Ohio Administrative Code Section 4731-27-01, a physician is required to provide services to a patient for as long as necessary or until the relationship is properly terminated. The physician has the right to withdraw from the care of a patient for any reason, if the relationship is ended appropriately and non-discriminatory. The terminated physician/patient relationship continues for up to thirty days after the termination letter has been mailed, during which time the physician will provide emergency treatment to the patient.

No Shows:
Cancellations and changes to appointments should be made as soon as possible so that another patient on our waiting list may fill that time slot.
If you fail to show up for your assigned appointment without canceling 24 hours in advance:

- A $25.00 no-show fee may be charged for general appointments, and a $50 fee for surgical appointments.
- We may be unable to provide care to you if you do not show up for three consecutive visits without appropriate notification.

Non-Medical Forms:

- For completing disability forms, mail-in prescription forms, handicapped sticker applications, etc., there will be a minimum charge of $15 payable in advance.
- Additional fees may apply if the physician is required to dictate multiple letters or if an extensive chart review is required.
- Releasing medical records may require a fee. Medical record fees cannot be paid by credit card.

Cosmetic Procedures:
Pre-payment/Deposit may be required for some procedures. Additionally, prepayment/deposits may be forfeited if you no show without appropriate 24-hour notice. All payments for cosmetic services and products must be made using cash or a credit card. Personal checks are not accepted for cosmetic procedures or products.

Pathology and Labs:
A separate charge will be applied for labs and pathology service if your office visit requires a biopsy or bloodwork. It is not known what your lab benefits are; however, 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.

It is your responsibility to read and understand the Financial Policy. Please sign below when you have done so. In case of questions or concerns, please let us know.

The above policies have been read and understood. Oakview Dermatology may receive benefits from my insurance carrier, or my insurance carrier may pay me directly. If any insurance payments are made directly to me, I understand and certify that I am financially responsible, so I agree to immediately pay Oakview Dermatology's charges for any healthcare services provided to me or my dependents, as well as any co-pays, deductibles, co-insurances, or amounts for services not covered.

In addition, I certify that I am responsible for any amounts not paid by insurance due to incorrect or incomplete billing information.

Patient's Name	**Date of Birth**
Signature of patient or responsible party	**Date**