

To my patients,

Welcome to my practice! This practice adheres to the principles of The Ideal Medical Practice Project. These principles are that I strive to provide you with the care you want, when you want it. I allow more time for each appointment and I work hard to provide ideal care for chronic disease management and well care. One goal of this style of practice is to help patients achieve an understanding of their illnesses and preventative care.

I see patients nearly every day I am in town, except for Wednesdays which are currently devoted to nursing home. I am available for emergencies by phone if I am not in the office and for evisits via my website. If you call my office, there is an option to connect to my cell phone. Please do not hesitate to call me if you have an urgent or emergent situation.

My goal is to offer same day appointments although sometimes it may be the next day. I am able to offer this for most routine as well as sick visits. Please remember to call early in the day and be flexible about appointment times. I will do my best to accommodate you.

I do the billing myself. Please notify me if you notice any mistakes. Copayment and deductibles are due at the time of service as per my contract with your insurance company. If I am not contracted with your insurance company and you choose to submit the bill yourself, I offer 50% off at the time of service. This discount applies as I do not spend the time on administration and do not have to wait for the funds. I will provide you with a detailed receipt (super bill) which you can submit.

Patient Information

First Name	Middle Name	Last Name
SS Number	Date of Birth	Age
Gender	Marital Status	
Address		
City	State	Zip
Student?	Work Status	Home Phone
Work Phone	Cell Phone	Email
Race	Emergency Contact	Emergency Contact Phone
Referred By:		

Responsible Party

Self?	Yes/No	(If No, please provide details below)
Relationship to Patient		
First Name	Middle Name	Last Name
Address		
City	State	Zip
Home Phone	Work Phone	DOB

Employment Details

Company Name	Start Date	
Address		
City	State	Zip
Phone Number		

Preventive Screening

Exam	Date	Exam	Date
Last Physical Exam		Last Mamogram	
Last Eye Exam		Last Breast Exam	
Last Dental Exam		Last Pap Smear	
Last Rectal Exam		Last Chest Xray	
Last Stool Occult		Last Cholesterol Test	
Last Sigmoid/Colonoscopy		Last Thyroid Exam	

Past History

Condition	Yes	No	Condition	Yes	No
Polio			Mumps		
AIDS			STD		
Blood Plasma Transfusion			Hepatitis		
Cancer			Depression		
Chicken Pox			Arthritis		
Epilepsy			Skin Disease		
Infectious Mono			Heart Problems		
Measles					

Past Illness History

Illness Name	From To	Unable to work?	Result

Past Surgical History

Surgery Name	Date	Place, Physician	Complications

OB/GYN History

Age of Menstruation	Frequency	Duration	Men. Flow
Menstrual Pain	Pre-Men Symp	Contraceptives	Last Men Date
H/O Fibroid	H/O Ovar Cyst	H/O Endometriosis	H/O Cerv. Canc
Childbirths - When	Where	Mode of Birth	Complications
Miscarriages - Why	When	Age of Fetus	Where

KRISTIN L. OAKS D.O. INC.
FINANCIAL POLICIES, EFFECTIVE FEBRUARY 1ST, 2011

We accept Cash, Check, Visa, and MasterCard for your convenience.

Private Pay: If you do not have insurance, payment will be due at the time of service. We offer a discount to all patients who pay in full at the time of service.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician participates in your specific plan. If your physician is not a participating provider for your plan, you may still select our office for your medical care; "out of network" benefits will apply. It is also your responsibility to know your insurance benefits. Our office cannot advise you of your insurance benefits. Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to coverage. As a courtesy to our patients, we will file insurance forms from our office. In order to do this, we require all information to be completed on the Patient Registration Form. We must have this information prior to your appointment. We will request an update to your information annually. Please present your insurance card at each appointment. A photo ID is required at your first visit.

If our office is unable to verify your insurance eligibility, you will be required to pay for your visit. If you provide the correct insurance information to our office in a timely manner, we will file a claim on your behalf. We will refund to you any portion that is determined to not be your responsibility.

You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier. Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan.

Billing: If you receive an invoice from our office for a balance due, it is because that is the balance your insurance policy requires that you pay. Please contact your insurance company first if you believe there is a problem. The balance on your invoice should be equal to the "Patient Responsibility" portion on your Explanation of Benefits that you received from your insurance company plus any "non-covered services" (less any copay that was collected at the time of service). If there is a discrepancy, please call our office immediately to request an explanation. You will continue to receive invoices and be subject to collections if you do not advise us of discrepancies.

Credit Card Authorization: For your convenience in paying the balance on your account, you may complete a Credit Card Authorization Form. You may specify a maximum dollar amount that we are authorized to charge each month. Non-covered services will be charged to this account if you are not present (such as for missed appointment fees, return check fees and

form completion fees). A copy of the credit card receipt will be mailed to you if we charge your account.

Collections: Invoices not paid within 60 days begin our in-house collection process. Invoices not paid within 120 days are subject to patient dismissal and submission to our Collections Agency and notification to your insurance plan.

Non-covered Services: The following services are considered "Non-Covered Services" by most insurance companies. The fees listed below must be paid at the time of service.

- **Returned Checks:** If your check is returned to us for any reason, you will be charged \$30
- **Missed Appointments:** If you fail to notify us at least 24 hours in advance that you will not be able to make your appointment, we may charge you \$25.

to whom we have not referred you for treatment.

- **E-visits:** Established patients may do an online visit with their provider via the website, www.drkristinoaks.com. The charge for these visits is increasing to \$35, payable via PayPal only prior to the visit. If your provider determines that an office visit is necessary, you will not be charged. Both Aetna and Cigna will be covering these visits as an insurance benefit, at the \$35 charge. For patients with those insurances, it is requested that you notify the office that you have either Aetna or Cigna by using the note section at the end of the evisit. Your insurance will be billed and we will reimburse your PayPal payment when the explanation of benefits is received by the practice.

- **Late Fees/Collections:** We will mail you two invoices, after which your account will be assessed a \$5 per month late fee if not paid in full. If we must remit your account to our collection agency, an additional 30% of the balance owing (including late fees) will be charged to your account.

Printed Name

Signature of responsible party

Date

Patient Consent Form

I hereby give my consent for **Kristin L. Oaks D.O. inc.** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (**Kristin L. Oaks D.O. inc's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy prior to signing this Consent. **Kristin L. Oaks D.O. inc** reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Kristin L. Oaks D.O. inc.** at **933 High St. Suite 116, Worthington, OH 43085.**

With this Consent, **Kristin L. Oaks D.O. inc** may mail to my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this Consent, **Kristin L. Oaks D.O. inc** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked **Personal and Confidential.**

With this Consent, **Kristin L. Oaks D.O. inc** may e-mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Kristin L. Oaks D.O. inc.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this Consent.

By signing this Consent, I am consenting to **Kristin L. Oaks D.O. inc's** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this Consent, or later revoke it **Kristin L. Oaks D.O. inc** may decline to provide treatment to me.

AGREED:

Patient's Name

Date

Patient's Date of Birth

Patient's Social Security Number

Signature of Patient or Legal Guardian