Patient Intake Form

Date:_____

Patient Name: (Last)_____ **(First)**_____
(M):_____

Cell Phone _____ **Home Phone** _____ **Work Phone**_____

Mailing Address: _____ **City:** _____
State:_____ **Zip:**_____

Home Address: _____ **City:**_____
State:_____ **Zip:**_____
(If Different)

Email_____ **How did you hear about us?**
_____

Birthdate: _____ **Age:**_____ **Sex:** ***M*** ***F*** **Marital Status: Married Single Divorced Separated Widowed Partner Decline to answer**

Race: White African-American Asian Ethnicity: Central American Cuban Dominican Hispanic/Latino Mexican Other_____
Decline to answer Other_____ **Not Hispanic/Latino Puerto Rican South American Decline to answer**

Social Security: _____ **Driver's License:**
_____
(If using insurance) **(If using insurance)**

Employer: _____
Occupation:_____

In case of emergency, contact: _____ **Relationship:** _____ **Phone:**
_____

Primary Dr._____
Pharmacy:_____
Are you using insurance for your visit? ***Y*** ***N*** **If yes please provide a copy of your card**

Parent/Guardian Info (if patient under age 18)
Name _____ **Mailing Address:**_____

Social Security:_____ **Home Phone:**_____ **Work Phone:**_____

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Dr. Olack will bill my insurance. I herby authorize Dr. J. Brian Olack to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Olack to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Summit Healthcare Plastic & Reconstructive Surgery for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

I hereby acknowledge that I have reviewed the Financial Agreement. I understand that copies are readily available upon my request.

_____ _____

_____

Signature of patient/responsible party/legal guardian Relationship to patient Date

Medical / Surgical History

Patient Name:_____ **Today's Date:**_____

Reason for today's visit?

_____

Age:_____ **Height:**_____ **Weight:**_____

List all medical providers you currently see (Including mental health):

List all medications which you are currently taking (including aspirin and non-prescription):

_____

_____

_____

Do you take herbal supplements or vitamins (especially Gingko, Ginger, Garlic, St. John's Wart, C, E, Fish oils)?

List all drug allergies (including latex):_____

Are you a smoker? *YES* *NO* If *YES*, how much:_____ **How long?**_____ **Quit how long ago?**_____

Do you drink alcohol? ***YES*** ***NO*** **If** ***YES,*** **how much:**_____

Have you had the following?

qYES qNO Chest Pain
qYES qNO Problems with Scarring
qYES qNO Pacemaker
qYES qNO Emotional Problems
qYES qNO Defibrillator
qYES qNO HIV
qYES qNO Heart Murmur
qYES qNO Dryness of Eyes
qYES qNO Mitral Valve Prolapse
qYES qNO Bleeding Disorders
qYES qNO Palpitations
qYES qNO Seizures
qYES qNO Shortness of Breath
qYES qNO Pregnant / Nursing
qYES qNO Heart Disease
qYES qNO High Blood Pressure

qYES qNO Anemia
qYES qNO Diabetes
qYES qNO Cancer
qYES qNO Breast Disease
qYES qNO Thyroid Disorder
qYES qNO Hepatitis *A B C*
qYES qNO Kidney Problems
qYES qNO Asthma

List all surgeries that you have had (including Plastic Surgery):
Date: **Surgery:**

_____
_____
_____

Please list immediate family medical History (Father, Mother, Siblings):

_____
_____
_____

Have you or anyone in your family ever had unusual reactions to anesthesia: ***Yes NO***

Do you have (circle all that apply): ***Loose or chipped teeth / Caps / Dentures / Contact Lenses***

Patient Signature_____
Date_____

Privacy Practices Acknowledgement

I hereby acknowledge that I have reviewed the Financial Agreement, the Outpatient Bill of Rights, the Summit Healthcare Notice of Privacy Practices, and the State of Arizona H.I.E. I understand that copies are readily available upon my request.

Summit Healthcare
PLASTIC & RECONSTRUCTIVE SURGERY

OLACK
PLASTIC SURGERY

_____

Patient Signature

_____

Printed Name

_____

Date

Contact Consent

We would like to follow up with our patients after a consultation and/or a procedure performed by this office. Please indicate your contact preferences below.

May we contact your home phone number?
YES ***NO***

May we send you a text reminder for your appointment?
YES ***NO***

May we identify ourselves as being from the office of Dr. Brian Olack?
YES ***NO***

May we leave a message on your voicemail?
YES ***NO***

May we send information to your home or mailing address?
YES ***NO***

May we send information via email?
YES ***NO***
If yes, please indicate email preference:_____

May we send you a survey regarding the care you received from our office via email?
YES ***NO***

May we speak with a family member or spouse regarding your care, results or medications?
YES ***NO***

Name:_____
Relationship:_____

_____ _____

Patient's Printed Name **Patient's Signature**
Date

Summit Healthcare Medical Associates Terms of Service

I acknowledge full financial responsibility of all charges for services rendered by Summit Healthcare Medical Associates (SHMA), including any amount not paid by my healthcare plan(s), other than billing terms and restrictions under a government program. I understand that payment of deductibles and co-pay amounts are expected at time of service, as well as any balance due owed to other SHMA entities. If I do not have my co-pay and my insurance card, I understand that I may be rescheduled. I agree that SHMA may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options.

Insurance Claims

In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, the insurance company makes the final determination of your eligibility and benefits If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. I consent to payment of authorized insurance benefits to be made directly to SHMA for any medical services furnished. If my health care plan(s) will not allow direct payment to SHMA, or if SHMA chooses not to accept assignment of medical benefits, I agree to pay SHMA all health care payments I receive for services. I authorize SHMA to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payment made under my heath care plan(s) to release such information to SHMA.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients without an insurance card on file with us, and patients in the grace period with their insurance premiums. Self-pay discounts are available with a signed affirmation of income. Self-pay patients must pay a minimum of $60 at the time of service. In the event of a financial hardship, please discuss payment options with the office manager.

Minors

The parent(s) or guardian(s) accompanying a minor child receiving medical services is responsible for payment of the minor child's services. If another party is also financially responsible, we will accept payment from the other party; however, that does not relinquish the accompanying parent(s) or guardian(s) responsibility to pay any unpaid balance. Newborns must be added to the parent's policy within 5 days of delivery.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent three statements. If no resolution can be made, the account will be sent to the collection agency or attorney, and could result in possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs. Additionally, once a patient is in collections, they will no longer be seen by any of the SHMA providers until the account is placed back in good standing or made whole.

Well Visits (Adults & Children)

If, during an annual well exam or OB visit, an acute illness/issue is addressed and/or treated, it may be considered a separate visit/encounter. This may result in an additional office visit copay, dependent upon your individual health plan benefits.

No Shows

A "No Show" is defined as: no notification given by the patient to cancel or reschedule an appointment prior to the appointment time. We ask that you give at least 24 hrs. notice of cancellation prior to your scheduled appointment time. No-shows greatly jeopardize the provider/patient relationship. We know that emergencies or unforeseen circumstances may cause you to no-show for an appointment; please let us know should this be the case. After 3 consecutive no shows, a patient may be terminated from the practice as per Summit policy.

Additional Fees

Additional fees may be charged for the following: Forms Fee $25 – No Show Fee $25 – Returned Check Fee $25

Consent to treat / Release of information

I consent to rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other SHMA medical staff considers being necessary. I may be offered medical services via telemedicine systems that involve the delivery of healthcare by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physicians, fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand the Authorization for Treatment and understand that no guarantee or assurance has been made as to the result that may be obtained. I authorize SHMA and my insurer(s) to share my past, current and future health, treatment and account records about the services I've received from SHMA and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

Thank you for choosing Summit Healthcare Medical Associates as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Consent to Treat is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Signed_____ Date_____
(Patient or Guardian/Guarantor)

Financial Agreement

General Agreement

I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and every effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied as to the results that may be obtained.

Problems and Complications

I understand and accept that problems relating to or complications of my surgery may result in additional costs to me. These costs may include additional anesthesia and facility fees, hospital costs, physician's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

Revisions and Touch – Ups

I understand and accept that on occasion "touch–ups" or revisions of surgery are necessary. I acknowledge that in such cases I am responsible for all operating room and anesthesia charges. I am also aware and accept that a surgeon's fee may also be charged, at my surgeon's discretion. I understand and accept that the need for, and timing of, revisions and touch-ups will be determined solely by my surgeon, as will the amount of the surgeon's fee.

Aesthetic Surgery Payment and Cancellation

A fee of $500 will be collected at the time of booking in order to schedule and secure a date and time in the operating room. Full payment will be required 14 days prior to the scheduled surgery date.

If, for any reason, I cancel my surgery 14 days prior to the date surgery is scheduled all payments are refundable.

If, for any reason, I cancel my surgery less than 14 days before my scheduled surgery date, my payment will be refunded less my non-refundable surgery scheduling fee. This will be forfeited and retained as a processing fee and not returned to me.

If my surgery must be cancelled because I fail to provide requested pre-operative lab work, X-rays, medical evaluation, history and physical, letter of medical clearance or other requested medical information, my payment will be refunded less my non-refundable surgery scheduling fee. This will be forfeited and retained as a processing fee and not returned to me.

If, for any reason, I fail to show for scheduled surgery without providing notice, my payment will be refunded less my non-refundable surgery scheduling fee, the aftercare fee (if any), and 50%of my quoted anesthesia fee, 50% of the facility fee, and 50% of the surgeon's fee. These will be forfeited and retained as processing fees and not returned to me.

Initials_____ Date_____

If surgery must be rescheduled, all fees will be applied to the new procedure date, and the cost will remain the same provided it is within 6 months of the original date. After 6 months, fees can still be applied, but there may be additional costs for anesthesia, facility, or surgeon's fee.

If a refund is needed, it will be issued in the form of a check even if a credit card payment was made. Please allow one to two weeks for processing.

Declaration
I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Summit Healthcare
PLASTIC & RECONSTRUCTIVE SURGERY

OLACK
PLASTIC SURGERY

_____

_____

Patient Signature **Date**

_____

_____

Witness signature **Date**