



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 hereby 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 Anemia |
| qYES qNO Problems with Scarring | qYES qNO Diabetes |
| qYES qNO Pacemaker | qYES qNO Cancer |
| qYES qNO Emotional Problems | qYES qNO Breast Disease |
| qYES qNO Defibrillator | qYES qNO Thyroid Disorder |
| qYES qNO HIV | qYES qNO Hepatitis <i>A B C</i> |
| qYES qNO Heart Murmur | qYES qNO Kidney Problems |
| qYES qNO Dryness of Eyes | qYES qNO Asthma |
| 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 | |

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.

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 health 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)