OAK MEDICAL
ONSITE PHYSICIAN SERVICES

Welcome to Oak Medical!

Oak Medical is a dedicated practice of medical professionals that provide care exclusively in Senior Living Communities. Our providers specialize in caring for seniors with chronic and acute health care needs while remaining patient-centered and communicating closely with residents and their family members.

If you chose to sign on to Oak Medical, we will become your sole Primary Care Provider. We encourage you to continue seeing any specialty providers you are already seeing. Please complete the following pages (Patient Enrollment Form, Consent For Treatment & HIPAA Acknowledgment Form, Authorization for Release of Health Information & New Patient Health Assessment) in their entirety if you would like Oak Medical to become your Primary Care Provider. These forms will help to ensure a smooth transition to our practice. Forms can be returned to your facility staff or directly to Oak Medical.

Please direct any questions to the staff at your community who will help you get in touch with Oak Medical. We look forward to working with you!

Please Return Completed Forms To
Email: oakmedAL@oakmedgroup.com or
Fax: 262-955-7298

WWW.OAKMEDGROUP.COM
262-875-5070
FAX 866-384-9486
N20W22961 WATERTOWN RD. WAUKESHA, WI 53186

Patient Enrollment Form

Patient Information: Please use full legal name. ☐ Memory Care ☐ Assisted Living ☐ Independent Living

First Name: _____ Last Name: _____ M.I. _____

Patient Date of Birth: _____ SSN: _____ Gender: ☐ M ☐ F ☐ Other

Email: _____

Community Name: _____ Room #: _____

Direct Phone #: _____ Preferred Pharmacy: _____

Insurance Information: Please submit a copy of your insurance cards.

Medicare ID #: _____

Primary Plan: _____ Policy ID #: _____ Group #: _____

Secondary Plan: _____ Policy ID #: _____ Group #: _____

Prescription Drug Coverage Name: _____ Plan ID #: _____

Legal Representative: Please submit a copy of your insurance cards.

☐ Self; I make my own medical decisions and have no activated Healthcare Power of Attorney or Legacl Guardian.

Name: _____ Relationship to Patient: _____

Phone: _____ Cell: _____

Email: _____ ☐ Allow Oak Medical Online Portal Access*

***Oak Medical Patient Portal**

The Oak Medical Patient Portal is a HIPAA compliant communications and health record system where you and/or people you authorize can stay updated or access important health information online and access the Oak Medical care team. Both are very important tools for delivering high quality healthcare and keeping everyone informed.

Consent for Access to Protected Health Information (PHI): People who have consent to receive information about your care.

Name: _____ Relationship to Patient: _____

Phone: _____ Cell: _____

Email: _____ ☐ Allow Oak Medical Online Portal Access*

Name: _____ Relationship to Patient: _____

Phone: _____ Cell: _____

Email: _____ ☐ Allow Oak Medical Online Portal Access*

Name: _____ Relationship to Patient: _____

Phone: _____ Cell: _____

Email: _____ ☐ Allow Oak Medical Online Portal Access*

Consent for Treatment & HIPAA Acknowledgement

Full completion of all the following information is *MANDATORY* for services.

Patient Information:

First Name: _____ Last Name: _____ M.I. _____

Patient Date of Birth: _____ Community Name & Room #: _____

Consent for Services & Disclosing Health Information: I consent to evaluation and treatment services determined by physicians, advanced practice providers, or designees of Oak Medical to be necessary and advisable. I also consent to the use and disclosure of my health information by Oak Medical for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Oak Medical that may be involved in my care. Oak Medical may disclose my health information to, and access my health information from, other providers using a record locator service or patient information service of a health information exchange for treatment.

Insurance & Payment Consent: I authorize payments directly to Oak Medical of insurance, Medicare or Medicaid Assistance benefits, or funds from other sources that I am entitled to as payment for any services I have received. I consent to the use and disclosure of my health information for payment purposes. In addition, my insurer may share my past, current, and future heal th and account records with Oak Medical about services received from Oak Medical and care providers unrelated to Oak Medical. These records may be used by Oak Medical as needed to manage, coordinate, and improve my quality of care.

Notice of Privacy Practice: I acknowledge that I have received a copy of Oak Medical's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Oak Medical may change its privacy practices in the future, that any changes will be presented to me, and that I can request a new copy of the privacy practices at any time. I also understand that I can contact Oak Medical's main office with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Oak Medical's health care operations.

Use of Health Information for Trainings & Evaluations: I give Oak Medical permission to use and disclose information gathered during my treatment from Oak Medical, including information from my records, for the purposes of program evaluation, training, and/or quality review of staff performance at Oak Medical.

Chronic Care Management Program (CCM): I consent to enrollment in the CCM program when appropriate. CCM is considered to be a critical component of primary care that has been found to contribute to better outcomes and higher patient satisfaction. We will work with you to create an individualized plan of care for your chronic conditions. You will receive education on those chronic conditions and have monthly telephone check ins between provider visits. CCM will be billed to your insurance with normal deductibles and copays. I understand that only one practitioner may bill for this service in a calendar month, and that I have the right to stop CCM services at any time.

This consent applies to health information that Oak Medical already has about me, future care I may receive, and any information Oak Medical receives from third parties. This consent will continue unless I provide written notice to Oak Medical revoking consents, or when it expires by law. Revoking my consent only will apply after the date when the notice is received. It will not affect any information that was used or disclosed prior to the cancellation.

By signing below, I understand Oak Medical will become my Primary Care Provider.

_____

Patient or Legal Representative Signature Date

_____

Relationship to Patient Printed Legal Representative Name Phone

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Authorization for Release of Health Information

Patient Information:

First Name: _____ Last Name: _____ M.I. _____

Patient Date of Birth: _____ Community Name & Room #: _____

Release Information From: (Include previous PCP and all Specialty Providers)

Clinic Name: _____

Previous Primary Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Clinic Name: _____

Specialty Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Clinic Name: _____

Specialty Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information May Be Released To:

Oak Medical, S.C. | Attn: Medical Records Department | N20W22961 Watertown Rd. | Waukesha, WI 53186

oakmedAL@oakmedgroup.com | fax: 262-955-7298

Information To Be Released:

- ☐ Last History & Physical or Annual Wellness Visit
- ☐ Labs within 6 months
- ☐ Tests or Scans within last 12 months
- ☐ Power of Attorney for Healthcare and/or Activation Forms
- ☐ Current Medication List
- ☐ Last Primary Care Provider Note

Completion of this form authorizes the release of the information described in the section above called “Information to be released.” The person whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. I understand this authorization to release healthcare information is voluntary. I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. This authorization is in effect while I am a patient of Oak Medical, S.C. I understand that this authorization may be revoked by me by written notice to Oak Medical, S.C.

As evidence by my signature, I hereby authorize disclosure of records to Oak Medical S.C.

_____

Patient or Legal Representative Signature Date

_____

Relationship to Patient Printed Legal Representative Name Phone

New Patient Health Assessment

Patient Information:

First Name: _____ Last Name: _____ M.I. _____

Patient Date of Birth: _____ Community Name & Room #: _____

Family Health History:

Has a family member (parents, siblings, children) had any of the following conditions listed?

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ High Blood Pressure ☐ Tuberculosis

Any other health concerns or conditions: _____

Personal Health History:

	Yes	No		Yes	No		Yes	No
Back Injury	☐	☐	Thyroid problem	☐	☐	Heart Disease	☐	☐
Seizures	☐	☐	Stomach or Gall Bladder trouble	☐	☐	Stomach Ulcer	☐	☐
Tuberculosis	☐	☐	Vision difficulty, eye disease	☐	☐	Difficulty Hearing	☐	☐
Hepatitis, Jaundice	☐	☐	Ear, nose, throat issues	☐	☐	Kidney Disease	☐	☐
Nervous Disorder	☐	☐	Chronic Pain	☐	☐	Muscular Disease	☐	☐
Respiratory Disease	☐	☐	Headaches	☐	☐	Mental Illness	☐	☐
High Blood Pressure	☐	☐	Fainting or Dizziness	☐	☐	Hernia	☐	☐
Diabetes	☐	☐	Arthritis, Gout, Joint Disease	☐	☐			
Cancer	☐	☐	Permanent defect from illness or injury	☐	☐			

Allergies: _____

List Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

Social History:

Do you currently smoke? ☐ Yes ☐ No How long have you smoked? _____

How many packs per day do/did you smoke? _____ If history of smoking, when did you quit? _____

Did you or do you currently use drugs? ☐ Yes ☐ No

How long have you used drugs? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week? _____ History of alcohol abuse? ☐ Yes ☐ No

Health Maintenance Screening:

Colorectal Screening (colonoscopy or fecal occult blood): _____

PSA Screening (men only): _____

Mammogram (women only): _____

Osteoporosis Screening (women 65+ and some men): _____

Last Annual Wellness Visit: _____

More concerns to be discussed with the provider:

_____