OAK MEDICAL
ONSITE PHYSICIAN SERVICES

WELCOME TO OAK MEDICAL!

Personalized, on-site medical care—right where you live.

Oak Medical provides on-site primary care exclusively in senior living communities. Our experienced providers care for older adults with chronic and acute medical needs while working closely with residents, families, and care teams.

By enrolling with Oak Medical, our providers will become your primary care provider, while continuing to coordinate with any specialists you already see.

Please complete the enclosed forms to begin care with Oak Medical.

STAYING CONNECTED

We encourage patients and families to use the Oak Medical Patient Portal as the easiest way to stay connected with your care team.

For questions or help, please contact your community staff.

Please Return Completed Forms To
Email: oakmedAL@oakmedgroup.com

ACCESS YOUR OAK MEDICAL PATIENT PORTAL

Patient Enrollment Form

□ Memory Care □ Assisted Living □ Independent Living **Facility:** ______________________

Patient Information: Please use full legal name.

First Name: ____

Last Name: ______________________________ M.I. ______________

Patient Date of Birth: ________________ SSN: ______________________

Gender: □ M □ F □ Other

Marital status: □ Single □ Married □ Divorced □ Widowed □ Separated

Race/Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino □ Native Hawaiian or Other Pacific Islander □ Caucasian

Primary language (and interpreter needs, if applicable): ______________________

Email: ____

Community Name: ____

Room #: ____________________ Phone #: ____________________

Preferred Pharmacy: ____

Drug allergies: ____

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:

□ Self; I make my own medical decisions and have no activated Healthcare Power of Attorney or Legal 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.

Consents & HIPAA Acknowledgment

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*

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

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
- Specialist Notes (Specialty: ____)

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.

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Patient or Legal Representative Signature | Date

____

Relationship to Patient | Printed Legal Representative Name | Phone