Oklahoma Integrative Medicine Center

New Patient Intake Form

We appreciate your help in updating your medical history page for our records. After completing this form to the best of your ability and comfort, please provide it to the staff member looking after you. Thank you and we look forward to taking care of you.

Name: _____ **Date of Birth**: _____

Marital Status: (Check all that apply)

Married ☐ Single ☐ Separated ☐ Widowed ☐ Partner ☐

Children ☐ None ☐ Number of own children: _____ Other: _____

Primary reason for Visit: _____

Current Medical Problems: (Check all that apply)

High Blood Pressure ☐ High Cholesterol ☐ Hypothyroidism ☐ Diabetes ☐

Overweight/Obesity ☐ Asthma/COPD ☐ Migraines/Headaches ☐ Back Pain ☐

Depression/Anxiety ☐ GERD (Reflux) ☐ Cancer – Type_____ Arthritis – Type _____

Other Diagnosed Conditions not mentioned above:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Surgeries: (Please list only MAJOR surgeries and dates M/Y, where possible)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Current Medications: (Please include dose and frequency if known. Attach additional sheets of paper)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies: (Check all that apply)

None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other: _____

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Specialists: Please list the names of all the specialty physicians who are currently providing services to you or have treated you in the past, including gastroenterologists who may have performed a colonoscopy for you)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Family Medical history: (Check all that apply, write relation and age when diagnosed if known)

High Blood Pressure: ☐ _____ Diabetes: ☐ _____
Heart Attack: ☐ _____ Strokes: ☐ _____
Lupus/Rheumatoid Arthritis: ☐ _____ Cancer: Breast ☐ _____
Cancer: Prostate ☐ _____ Cancer: Colon ☐ _____
Other:_____

Habits:

Current Tobacco Use: (Click all that apply)

YES ☐ ____ Pack per day x _____ years NO ☐ Former ☐ Quit in _____ (years)

Current Alcohol Use: (Click all that apply)

YES ☐ ____ per day/week x _____ years NO ☐ Former ☐ Quit in _____ (years)

Current or Past Illicit Drug Use: _____

Sexual Preference: (Click all that apply)
Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other ☐

Exercise: (Check all that apply)
Daily ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ 0 ☐ Times/week

Wellness and Prevention:

Colonoscopy: ☐ Date:_____ Stool Card Test: ☐ Date:_____ PSA Test: ☐ Date:_____
Prostates Exam: ☐ Date:_____ PAP: ☐ Date:_____ Mammogram: ☐ Date:_____
Bone Density: ☐ Date:_____ Other: _____

Adult Immunizations:

Flu: ☐ Date: _____ ☐ I DO NOT TAKE
Pneumonia: ☐ Date: _____ ☐ I DO NOT TAKE
Tetanus: ☐ Date: _____ ☐ I DO NOT TAKE

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Child immunization (for pediatric use only)- Please attach a separate copy of most recent Immunization Record.

At your discretion, please submit copies of other health information records such as Health Care Proxy, Advance Directives, DNR, etc. to the Front Desk for entry into your Medical Record.

To be completed by Weight Loss Patient ONLY:

Height ____ft ____in Current Weight _____ pound Goal Weight _____ pound

How many pounds would you like to lose? _____

Have you tried to lose weight on your own through a balanced Diet and Exercise Plan? Yes ☐ No ☐

Have you tried to lose weight by enrolling in a program like Weight Watchers or similar? Yes ☐ No ☐

Are you interested in Medical Weight Loss plan to lose weight? Yes ☐ No ☐

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Patient Registration Form

Last Name: _____ First Name: _____
Date of Birth: _____ Male ☐ Female ☐
Married ☐ Single ☐ Other ☐
Address: _____ City: _____State: _____
Home Phone: _____ Cell: _____
Email: _____ SSN: _____
Employer: _____ Work Phone: _____
Referring Dr (first and last): _____Tel: _____
Primary Care (first and last): _____ Tel: _____
Self-Pay? Yes ☐ No ☐

Insurance information (Primary)
Insurance Company Name: _____
Policy Holder's Name: _____ Date of Birth: _____
SSN: _____ Relationship to Patient: _____

Insurance information (Secondary)
Insurance Company Name: _____
Policy Holder's Name: _____ Date of Birth: _____
SSN: _____ Relationship to Patient: _____

Responsible Party (if different from patient)
Last Name: _____ First Name:_____
Date of Birth: _____ Address:_____
Tel. _____ SSN: _____ Male ☐ Female ☐
Employer: _____
Emergency Contact (someone NOT living with you)
Last Name: _____ First Name: _____
Address: _____ Relationship: _____
Tel: _____

Referred by: Doctor ☐ Family ☐ Friend ☐ Website ☐ Advertisement ☐

I hereby assign payment of medical benefit to Dr. Angelique Barreto M.D. for all services needed. I understand that I am financially responsible for all charges, whether or not paid by the above said insurance companies:

Date: _____ Signature: _____

Please list people with whom we can discuss your care and leave messages.

1) _____ Relationship Ph: _____
2) _____ Relationship Ph: _____

May we leave messages on your answering machine regarding your care? Yes ☐ No ☐ (please understand that if we cannot leave message, it will be your responsibility to initiate contact with us regarding follow up of lab, appointments, etc.

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Due to recent federal regulation, Oklahoma Integrative Medicine Center is required to update your medical records with the following information. Please fill this information out to the level that you are most comfortable with.

1) Occupation _____

2) Education – less than 8th grade ☐ 12th grade ☐ 2 yr college ☐ Bachelor Degree ☐
Post Grad ☐

3) Marital Status – Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐

4) Sexual Orientation – Heterosexual ☐ Homosexual ☐ Bisexual ☐

5) Smoking Status – Never smoked ☐ Former smoker ☐ Current every day smoker ☐
Current someday smoker ☐

6) Smoking Amount – None ☐ 1PPW ☐ 2PPW ☐ ¼ PPW ☐ ½ PPW ☐ 1 PPD ☐
1 ½ PPD ☐ 2 PPD ☐ 3+PPD ☐

7) Exercise level – None ☐ Occasional ☐ Moderate ☐ Heavy ☐

8) Alcohol intake – None ☐ Occasional ☐ Moderate ☐ Heavy ☐

9) Chewing tobacco - None ☐ 1 day ☐ 2-4 days ☐ 5+ days ☐

10) Illicit drugs – Yes ☐ No ☐

11) Advance Directive – Yes ☐ No ☐

12) Substance abuse – Yes ☐ No ☐

13) Tobacco – years of use - _____

14) Number of children - _____

15) History of blood transfusion – Yes ☐ No ☐

Clinical Policy

Thank you for choosing out clinic for your medical care. The following is a statement of our Clinic Policies and Procedures. We ask you to please read this statement, agree to, and acknowledge prior to any services being provided.

1. Co-Pays, co-insurance and deductibles Policy

We require that all co-pays (as per your insurance mandate), outstanding co-insurance and deductible payments be paid at the time of check-in PRIOR to services being rendered. We accept (Cash/CERTIFIED Checks/Debit Cards/Credit Cards).

2. Insurance claims Policy

Dr. Barreto's office accepts most insurance plans and our Billing Specialist will file your medical charges with your health insurance as a courtesy to you. It is your Medical Provider's responsibility to medically recommend tests and treatments you need.

Please remember that you are ultimately responsible for your medical bills.

- Please bring CURRENT Insurance Card to all visits.
- Please ensure that Angelique Barreto, MD is a contracted provider on your health insurance PRIOR to your visit.
- It is your responsibility to resolve any issues with your Insurance Plan within 60 days of service. If there is NON-PAYMENT or DELAYED PROCESSING.
- Unpaid Balances are due from you at 90 days from date of service.
- If payment is not received by the due date stated on your 90-day statement, your account will be turned to a collection agency and no further services or appointments will be provided by our clinic.
- The Billing Specialist and Front Desk will work with you to provide billing information you need and set up Payment Plans if requested.

3. Office Visits

Multiple medical issues will no longer be addressed in one office visit. Additional CO-PAYs and office visit charges will apply.
All lab discussion visits are billed as prolonged office visits due to our patient care time totaling 45 mins or more.

4. Missed and Late Appointment Policy

- Dr Barreto requests you to provide 24-hour advance notice to cancel an appointment. This allows her to fill your slot with another sick patient who may be in urgent need of care. Failure to provide us 24-hour notice will result in a charge of $30 being applied to your account.
- If you are late for your appointment, the clinic reserves the right to re-schedule your appointment to a later date and time.

5. Prescription Policy

- Please bring a list of your medications to your appointments. You will be given refills until your next follow-up lab draw or appointment. It is YOUR RESPONSIBILITY to ensure that your pharmacist receives these prescriptions to keep in your life.
- If you are unwell or wish to have a medication dose adjusted, and wish to receive medical advice or prescriptions, please request an URGENT CARE only appointment by calling SCHEDULING on (405) 749-0900. Dr. Barreto does her best to see Urgent patients within 24-hours.
- No Controlled substances and anti-biotics can be called in for patients AFTER HOURS.

6. Forms and Letters Policy

You are required to make a separate 20-minute office visit to explain the medical need for your form or letter to a provider. This has to be documented in your medical records by the provider and provided to authorities on request. Please obtain all the necessary information from your employer or other requesting authority to enable the form or letter to be filled out correctly. Please fill in your personal information on the form prior to the visit. Certain forms like Handicap sticker forms carry standard charges which are available on request at the front desk.

7. Referrals and Prior Authorization Policy

You are required to schedule an appointment with a provider prior to a referral being sent by our clinic. This allows for the correct paperwork to be sent to your insurance and Specialist or another provider. Referrals and Prior Authorizations are currently being done by the Referral Specialist in our clinic as a COURTESY TO YOU.

PLEASE READ CAREFULLY AND ACKOWLEDGE YOUR RECEIPT OF A COPY AND YOUR UNDERSTANDING OF THE CLINIC'S POLICIES AND PROCEDURES BY SIGNING AND DATING IN THE SPACES BELOW.

Printed Name: _____
your common name here

Signature: _____

Date: _____

PATIENT FINANCIAL AGREEMENT

Effective October 17, 2016

CO-PAYS:

1. All Co-pays are due on the date of service.
2. Due to the amount of returned checks received in our clinic, we are no longer accepting personal checks We do however accept CERTIFIED Checks lauded by a valid Financial Institute. If you are unable to pay your co-pay on the day of your appointment, your appointment will be rescheduled.

OUTSTANDING BALANCES:

1. Account balances must be paid entirely prior to scheduled office visit. Provider reserves the right to re-schedule/cancel appointments if balance is not paid.
2. At Provider's discretion, a payment plan will be offered if patient is in need.
3. NO services will be provided as long as patient has a past due balance on their account and has not been compliant with the agreed payment plan.
4. Any payment arrangement not fulfilled on time will need to be made in full before future office visits are made.

I understand and agree to the above Patient Financial Policy by signing below.

here

_____ _____

Patient's Signature Date