William M. Thompson, IV, MD, Inc.

Patient Information

_____ _____

Legal First Name, Middle, Last Preferred Name

Sex _____ Date of Birth _____ SS# _____ Email _____

Address _____ City _____ State _____ Zip _____

Mobile # _____ Home # _____ Work # _____

Occupation _____ Employer _____

Emergency Contact _____ Contact # _____ Relation _____

How did you hear about us? _____

Guarantor Information (If different from patient)

Name _____ Relation to patient _____

Address _____ City _____ State _____ Zip _____

Contact # _____ Date of Birth _____ SS# _____

Insurance Information

Primary Insurance _____ Policy # _____ Group # _____

Type of Coverage: PPO, HMO, Medi-cal, Medicare, Medicare supplement, Other _____

Secondary Insurance _____ Policy # _____ Group # _____

Type of Coverage: PPO, HMO, Medi-cal, Medicare, Medicare supplement, Other _____

___ NO Insurance Coverage, Cash Patient. NOTICE: All Fee's must be paid at the time of service.

Cash rates: First Consultation $300.00, Follow-up visits $100.00

I acknowledge that the information listed above is complete and true to the best of my knowledge.

Patient Signature _____ Date _____

William M. Thompson, IV, MD, Inc.

Health History

Patient Name _____ Date of Birth _____

Allergies to Medications or Foods ____ No Allergies _____ Patient Initials

Type	Onset	Reaction

List of Current Medications (If more space is needed please list on back of this page.)

Medication	Dosage	Frequency	Reason

Do you or have you ever used tobacco? Yes___ No ___

Type _____ Frequency _____ Start Date _____ Quit Date _____

Do you or have you ever used drugs? Yes ___ No ___

Type _____ Frequency _____ Start Date _____ Quit Date _____

Do you drink Alcohol? Yes ___ No ___

Type _____ Frequency _____ Start Date _____ Quit Date _____

Preferred Pharmacy: _____ Phone # _____ Location _____

Preferred Laboratory: _____ Phone # _____ Location _____

Primary Physician _____Phone # _____Fax # _____

Address _____

William M. Thompson, IV, MD, Inc.

Financial Policy

1. As a courtesy to our patients, we will accept assignment of insurance benefits. We do require payment of any uncovered portion, such as deductibles and co-payment, to be paid at the time of service.
2. The balance due is your responsibility whether or not your insurance company pays for any portion of the total amount billed.
3. Our practice charges what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
4. **Out-of-Network Plans.** In cases when we are not a provider for your insurance, your visit will be an out-of-network service for which you will be responsible. Your insurance may impose a deductible or higher co-payments for out-of-network physicians. If you do not have out-of-network benefits, you are responsible for any or all unpaid charges denied by your insurance company.
5. It is your responsibility to know and understand your policy provision and to inform this office.
6. If your account must be forwarded to a collection agency for nonpayment after 90 days, you will be responsible for all collection fees charged by the agency. A fee of $ 45.00 will be added to your account before it is assigned to the collection agency.

Initials _____

Missed Appointments Policy

Our practice has a fee of $100.00 for any missed or cancelled appointments without sufficient time notice (At least 24 hours). We schedule our patients in a timely manner and don't double book appointments. When an appointment is given to you, that time is blocked off specifically for you. If you miss or cancel without sufficient time notice, it prevents us from treating another patient, resulting in wasted time for the physician.

We understand that emergencies do happen and adequate notice is not always possible. We do ask that you notify us as soon as you realize that you will be unable to make your appointment, to avoid any charges.

As a courtesy, our office staff tries to confirm all appointment the day prior. However, sometimes circumstances arise that prevent us from calling. Please do not rely on the confirmation call to remind you of your appointment. If you have any questions regarding your appointment day or time, please contact our office.

Initials _____

I acknowledge that I have read the above policies and agree to comply with the terms and conditions outlined in each of the policies.

Patient Signature _____ Date _____

William M. Thompson, IV, MD, Inc.

Office Policy

Office Hours: Monday - Wednesday 9am - 5pm, Thursday 8am - 4pm, Friday 8am -12pm.

** For any urgent medical issues outside of our office hours, please call our office number to be connected to the on-call physicians paging service. Please dial 911 for all medical emergencies.

Appointments:

- Urgent appointments- If you are required to be evaluated sooner than the next available appointment, please let our staff know and we will try to accommodate you either the same or following day.
- It is important for you to keep your scheduled appointments, complete requested tests and take your prescribed medications to receive the best possible care and treatment from our physician.
- Appointment cancellations- Please contact our office as soon as you are aware that you will be missing or to request a change in appointment time and/or date. Any notifications less than 24 hours may result in acquired fees (please refer to our 'Missed Appointment Policy', page 3).

Forms/Administrative Fees:

- Any forms requested to be filled out by the physician may require an appointment, due to required evaluation and or laboratory tests. Please call our office for any questions.
- Our office has set fees for any forms that need to be filled out by the physician or staff. All fees for administrative requests must be pre-paid. Please allow our office up to 3 business days to complete all requests. Please contact our office for fees or questions.

Medication Refills:

- It is imperative to your treatment to follow instruction on any prescribed medications. In order to avoid any disruption in your treatment, please request a refill from your pharmacy when picking up your last refill.
- All medication refills or requests need to be submitted directly to your pharmacy.

Laboratory/Procedure Results:

Due to the highly sensitive health information obtained through the results of any laboratory or radiology/imaging studies, appointments are required to interpret any results. Therefore, we do not discuss any test results over the telephone.

I acknowledge that I have read and understand the above listed office policies.

Patient Signature _____ Date _____

William M. Thompson, IV, MD, Inc.

Patient Consent for Use and Disclosure of Protected Health Information.

I hereby give my consent for William M. Thompson, IV, MD, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations.

The Notice of Privacy Practices provided by William M. Thompson, IV, MD, Inc. describes such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

William M. Thompson, IV, MD, Inc reserves the right to revise its Notice of Privacy Practices at any time. A revised copy may be obtained by submitting a request to our office.

I have the right to revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, William M. Thompson, IV, MD, Inc may option to decline services to me.

Print Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices.

I hereby acknowledge that I have received a copy of William M. Thompson, IV, MD, Inc Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request at any time a copy of any amended Notice of Privacy Practices.

I would like to receive a copy of the Notice of Privacy Practices in paper form. _____ Initials.

I would like to receive a copy of the Notice of Privacy Practices in electronic form. _____ Initials.

Email _____

Print Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____