

Welcome to Our Practice

Please make sure we get a copy of your Health Insurance card & Drivers License

Who referred you? (If 1st visit to office) _____ Date: _____

Patient Name _____ Date of Birth: _____

Home Number _____ Cell Number _____

Height: _____ Weight: _____ Age: _____

Home Address: _____ City: _____ Zip: _____

Social Security Number: _____ Primary Physician (PCP) _____

Reason for visit: _____

Is visit related to on-the-job injury: (circle one) YES or NO If yes, date of injury: _____

History of present illness

Location _____ Frequency _____
(Where is pain/problem located) (How often does this occur)
Duration _____ Level of Pain 0 1 2 3 4 5
(How long have you had this) LOW (circle one) HIGH

Patient Medical History

Do you have or have you ever had the following: (please check all that apply)

Bleeding Tendency _____ Cancer _____ Blood or Plasma Transfusion _____
Heart Disease _____ Asthma _____ Ulcer _____
Aids or HIV+ _____ Hernia _____ Mitral Valve Prolapse _____
Thyroid Disease _____ Hepatitis _____ Stroke _____
High Blood Pressure _____ Low Blood Pressure _____ Gallbladder Disease or Gallstone _____
Diabetes _____ Kidney Disease _____ Myeloma _____

Previous Hospitalizations/Surgeries: (use back if needed!) _____ When (year) _____

Any Metal placements that would affect a scans image: (please list): _____

Medications: (Include non-prescription) with daily dosage and frequency taken: (or provide copy of list)

Drug Allergies & Reactions:

Do you have Allergies to the following: (please check that apply) Shellfish _____ Iodine: _____

Social History

Use of Alcohol: _____ Never _____ Rarely _____ Moderate _____ Daily
Use of Tobacco: _____ Never _____ Daily _____ # of packs per day Previously but quit _____ (year) _____

WOMEN ONLY: Date of last menstrual period: _____

Robert P. Thompson MD PA

Assignment of Benefits

I certify that the information I have given to Robert P. Thompson MD PA, PA, hereinafter ROBERT P. THOMPSON MD, is true and correct to the best of my knowledge. I promise to pay Robert P. Thompson MD PA, PA all charges and expenses for services provided to me in accordance with the current fees and charges to the extent that the fees and charges are not covered or paid by my insurance(s).

I request that payment of authorized benefits under any private or government insurance program be made on my behalf to ROBERT P. THOMPSON MD for services furnished to me by the providers of ROBERT P. THOMPSON MD. I authorize any holder of medical information about me to release to third party reimbursees and its agents any information needed to determine benefits if applicable. ROBERT P. THOMPSON MD may pursue collection of these benefits in my name or in the name of ROBERT P. THOMPSON MD. I also authorize the use of a copy of this authorization in place of the original. I understand that possession of medical insurance does not relieve me of financial responsibility to ROBERT P. THOMPSON MD. I will personally be responsible for all charges for services that are not covered by my health insurance.

Date

Signature of Patient or Guardian.

- It is okay to leave a Message/Voicemail on phone numbers given.
- It is NOT okay to leave a Message/Voicemail on phone numbers given.

It is okay to leave medical information with (spouse or family member)

Name: _____

Phone: _____

Relationship: _____

Robert P. Thompson MD, r

Payment Policy

Thank you for choosing Robert P. Thompson MD as your healthcare provider. We are committed to providing you with quality health care. A copy of this pmt policy will be provided to you upon request.

Insurance Our office participates in several insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit, unless otherwise negotiated with your health plan. If you are insured by a plan we do business with, but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles All co-payments and deductibles must be paid at time of services being rendered. This arrangement is part of our contract with your insurance company. Please help us in upholding our agreement with your insurance company by paying your co-payment at each visit.

Non-covered services Please be advised that certain services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full prior to that service being rendered, unless otherwise negotiated.

Proof of insurance All patients must complete our patient information form before seeing the physician. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.

Claims submission Our billing offices will submit your claims and assist you in any way we reasonably can to help get your claims processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Requested information not provided to your insurance company in a timely manner will be transferred to your responsibility. After 90 days of non-payment by the insurance company, the balance will be forwarded to patient responsibility.

Coverage Changes If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive the maximum benefits. Information changes not provided prior to services being rendered will result in a denial of the claim and the balance will be your responsibility. Many of the contracts with the plans require us to file claims in a timely manner. Claims denied as past the filing deadline for incorrect information received will be transferred to your responsibility.

Missed Appointments Our policy is to charge **\$25.00** for missed appointments not canceled within 24 hours prior to the date of appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date