

**THOMPSON SURGICAL ASSOCIATES**  
**PATIENT INSURANCE/PERSONAL INFORMATION**

Thompson Surgical Associates will bill your insurance carrier if proper coverage verification is received. If your insurance requires a referral from your PCP, you are responsible for getting the referral. Please complete the required insurance information & acknowledgement fields below, as well as the insurance & financial policies page attached. Please bring with you a valid picture ID and insurance card to your appointment.

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Preferred Phone#** \_\_\_\_\_ **Secondary Phone#** \_\_\_\_\_

**Marital Status:** Single Married Divorced Widowed Other **Sex at Birth:** Male Female

**Ethnicity/Race** \_\_\_\_\_ **Employed:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Preferred Contact Method** Phone Email **Can we leave a voicemail?** Yes No

**Social Security # (required)** \_\_\_\_\_ **Email** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Person Responsible for Insurance Account:**  
\_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_

**Address (if different from patient)** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Ins. Company** \_\_\_\_\_ **Contract/Subscriber #** \_\_\_\_\_

**Name of Secondary Ins. Company**  
\_\_\_\_\_

**Contract/Subscriber #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Insureds Name (if different from Patient)** \_\_\_\_\_

**Relation to Patient** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Soc. Sec #** \_\_\_\_\_

1. I understand that I am financially responsible for all charges not paid by my insurance, with payment expected from me within 30 days of statement notification. I understand that non-compliance with payment terms can immediately result in my forfeiture of any and all insurance billing options extended to me by Thompson Surgical Associates
2. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to my doctor at Thompson Surgical. A photo static copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

# Insurance and Financial Policies of Thompson Surgical Associates

## Insurance:

\_\_\_\_\_Initial

Some providers participate or contract with certain insurance companies. If we do not participate with your insurance company at the time, we may still be able to bill as an out-of-network provider. Knowing your insurance coverage is your responsibility – please contact them with questions about your coverage before your visit.

In some cases, care agreed to be medically indicated by the physician and the patient may not be covered by insurance (example: lab work, annual exams, pre-existing conditions, etc) and you will be required to pay for those services. Please check with your insurance company to find out if there are any exclusions in your individual policy. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment by them. It is not uncommon for an Insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsible to follow up if a claim is not paid. Please be aware that you, the patient, are responsible for the balance of your claim as decreed by your insurance company.

## Co-Payments & Deductibles:

\_\_\_\_\_Initial

By signing this agreement you agree to pay your copay, co-insurance and or deductible and any fees that your insurance does not cover. Copays or co-insurance is an arrangement between you and your insurance company. Failure on our part to collect copays, co-insurance and deductibles from patients could be considered fraud. Please be informed about your copays, co-insurance and deductibles. If you have a large deductible we require a \$1000 payment before any procedures can be done. This payment is to be made in cash, debit or credit.

## Proof of Insurance:

\_\_\_\_\_Initial

All patients with insurance coverage must complete the patient intake forms and provide current valid insurance cards. This card will be copied and stored with your patient chart. If insurance coverage changes or expires please provide a current card as soon as it is issued.

## Self-Pay:

\_\_\_\_\_Initial

If you do not have insurance, payment in full is expected prior to services rendered.

## Non-Payment

\_\_\_\_\_Initial

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, your account may be referred to a collections agency and charged a processing fee of \$75 and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis. It is your responsible for all fees incurred to obtain payment. There is a \$35 fee for returned checks to cover bank fees.

## Authorization:

I have read the above TWO pages of information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any changes to my insurance coverage.

AND

I authorize the release of any medical or other information necessary to process any claims

AND

I authorize payment of medical benefits to y Thompson Surgical Associates/Jeffrey Thompson, M.D.

AND

I authorize the release of any medical records to Jeffrey Thompson, M.D. that may aid in my treatment.

Name: (print) \_\_\_\_\_ Signature \_\_\_\_\_

IN CASE OF EMERGENCY who should be notified: \_\_\_\_\_ Phone# \_\_\_\_\_

Person or persons we are allowed to share medical information with: \_\_\_\_\_ Initial

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Relation \_\_\_\_\_

**THOMPSON SURGICAL ASSOCIATES**  
**Dr. Jeffrey H. Thompson**

<b>PATIENT NAME:</b>	<b>DATE OF BIRTH:</b> ___/___/___
<b>HEIGHT:</b> ___ <b>WEIGHT:</b> ___	
<b>WHAT IS THE REASON FOR YOUR APPOINTMENT:</b>	<b>ONSET</b> ___/___/___
<b>LIST ANY RECENT TESTING OR IMAGING AND FACILITY PERFORMED:</b>	
<b>LIST ANY SYMPTOMS ASSOCIATED:</b>	

<b>PATIENT MEDICAL HISTORY</b>		<b>CHECK IF YES</b>
<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Endocrine Problems <input type="checkbox"/> GERD <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcerative Colitis

<b>MEDICAL HISTORY:</b>		

**PATIENT SURGICAL HISTORY**

CHECK IF YES

<input type="checkbox"/> Adrenal Gland Surgery	<input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Kidney Surgery
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Artery Bypass Graft	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Esophagus Surgery	<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Bladder Surgery	<input type="checkbox"/> Gastric Bypass Surgery	<input type="checkbox"/> Small Intestine Surgery
<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Hemorrhoid Surgery	<input type="checkbox"/> Spine Surgery
<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Stomach Surgery
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Thyroid Surgery

**SURGICAL HISTORY:**


<b>LAST COLONOSCOPY</b>	<b>FACILITY</b>

<b>LAST MAMMOGRAM</b>	<b>FACILITY</b>

<b>FAMILY HISTORY</b>	<b>Check if YES</b>	<b>RELATION</b>
Cancer _____		
Colon Cancer		
Lymphoma		
Heart Disease		
Reaction to Anesthesia		
Bleeding Disorder		
Blood Clots		

<b>SOCIAL HISTORY</b>	<b>Check if YES</b>
Occupation _____	
Retired	
Married	
Tobacco Use	
Alcohol Use	
Illicit Drugs or non-prescription medication	

**PATIENT MEDICATION HISTORY**

**PHARMACY:**

ALLERGY TO LATEX?	SHELLFISH?	IODINE?

DRUG ALLERGIES	REACTION	SEVERITY

MEDICATION	STRENGTH	FREQUENCY

**Pre-Admission Pre-Screening**

What phone number does the Pre-Admit Nurse need to call for your phone interview?

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Please provide a Secondary Phone Number if the nurse is unable to reach you:

Name \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number \_\_\_\_\_

**\*\*\*Does The Nurse have permission to obtain/discuss your health history and give instructions for your up coming procedure with this person?**

Circle YES / NO

Do you take a Diet Pill or Inject-able for Weight loss? \_\_\_\_\_

**\*\*\*These medications will need to be heald prior to anesthesia for your safety, directions will be provided by the Nurse at the time of your phone Interview\*\*\***

Who is your Primary Medical doctor: \_\_\_\_\_ Location: \_\_\_\_\_

Cardiologist: (Heart Doctor) \_\_\_\_\_ Location: \_\_\_\_\_

Neurologist: \_\_\_\_\_ Location: \_\_\_\_\_

Pulmonologist: (Lung Doctor) \_\_\_\_\_ Location: \_\_\_\_\_

Do you have any upcoming appointment with any of your Specialist?

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Have you had?	Yes	When	Location
EKG			
ECHO/Ultrasound of your Heart			
Stress Test			
Are you taking a blood thinner?	Name Of Medication: _____		

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Pre-Screening Assessment BP: \_\_\_\_\_ HR: \_\_\_\_\_ Sat: \_\_\_\_\_ Temp: \_\_\_\_\_

Please check if you have ever had any of the following:

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

	Check if YES	Answer if checked Yes
Asthma		Flare Up in the last 2 months: Y / N Inhaler/TX: Y / N
Blood Pressure Problems		Do you Take Blood Pressure Medication? Yes/ No
Cardiomegaly (Enlarged Heart)		
CHF (Congestive Heart Failure)		
COPD		Have you had an exacerbation in the last 4 weeks? Y / N
Chronic Kidney Failure		Are you on Dialysis: Yes / No
CABG / Open heart surgery		Year / How many Bypasses:
Diabetes		Average Blood Sugar: _____ Most Recent HBG A1c: _____ When:
Heart Attack / MI		When:
Heart Catheterization / LHC		When: Did you get stent (s): yes/ no
Irregular Heartbeat		What type:
Pulmonary Hypertension		
Pneumonia in the last 2 months		
Seizures		Are you on medications: Last Seizure:
Sleep Apnea		Do you use a Cpap: Yes / No
Stroke		When: Do you have any weaknesses: Yes / No Have you seen a Cardiologist or Neurologist? Yes / No

Do you smoke or have a history of smoking?

Former: Been Quit for \_\_\_ years HX \_\_\_ ppd x \_\_\_ years

Current daily smoker \_\_\_ ppd x \_\_\_ years

Daily Alcohol Consumption : Drink of choice/number of drinks \_\_\_\_\_

Have you experienced any of these symptoms **in the last 6 weeks:**

Dizziness                      Syncope/passed out                      Shortness of Breath

Light headedness                      Racing Heartbeat                      High Blood Pressure

Palpitations                      Chest pain/tightness

Do you get short of breath with daily activities? Yes / No

Can you walk a City Block without getting short of breath or having chest pain/palpitations? Yes / No

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_