I|D

Dr. William Thompson IV

Office Hours
Monday through Friday: 9:00 am - 5:00 pm

After Office Hours
For urgent medical issues after regular office hours, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours.

Same Day / Urgent Appointments
We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you as best we can.

Emergencies
Call 911 for medical emergencies.

Medication Refills
We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" via our online portal or using e-scripts when you are picking up your last refill. Please allow 3-4 working days for us to refill your medications. We charge $50.00 for a Prior Authorization to be completed. We do not guarantee it will be approved.

Forms
Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to complete. We charge $50.00 for a form to be completed.

Medical Care
We are concerned about your health. In order for us to provide the best possible quality of care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you.

Canceling Appointments
If for any reason you will not be able to keep your appointment, we ask that you notify us to reschedule at least 24 hours prior to your appointment. We charge $40.00 for an appointment not cancelled timely.

Other Physicians or Heath Care Specialists
If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies.

Communication
We believe in having good communication between our office staff and our patients. We encourage you express any questions or concerns to us, so we may better serve you.

Termination of Care: If you have not been seen by the doctor within the last 12 months, you will be required to complete a new Patient Intake Form.

**All New Patient Forms must be completed and signed at or prior to your first appointment.*

PATIENT INFORMATION

LEGAL LAST NAME: LEGAL FIRST NAME: MIDDLE INITIAL: NAME YOU PREFER TO BE CALLED:				SEX ASSIGNED AT BIRTH
ADDRESS APT # CITY STATE ZIP				
SOCIAL SECURITY #	BIRTHDATE	PREFERRED CONTACT # (home or cell)	ALTERNATE PHONE #	
WORK TELEPHONE #	E-MAIL ADDRESS			
EMPLOYER EMPLOYER ADDRESS POSITION/ TITLE				
EMERGENCY CONTACT NAME & TELEPHONE NUMBER				
WHO REFERRED YOU TO OUR OFFICE?				
WHO IS YOUR PRIMARY PHYSICIAN? TELEPHONE #				
PHYSICIAN ADDRESS				

GUARANTOR/ POLICY HOLDER INFORMATION

LAST FIRST NAME M.I.			RELATIONSHIP TO PATIENT SPOUSE PARENT OTHER:
ADDRESSS IF DIFFERENT FROM PATIENT			
BIRTH DATE	SOCIAL SECURITY #		
GUARANTOR/ POLICY HOLDER'S EMPLOYER EMPLOYERS ADDRESS CITY STATE ZIP			

INSURANCE INFORMATION

1. PRIMARY INSURANCE PLAN		GROUP NUMBER		POLICY NUMBER			
TYPE OF PLAN OR COVERAGE HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER							
POLICY OWNERS NAME (GUARANTOR)		IPA		PRIMARY CARE PROVIDER			
2. SECONDARY INSURANCE PLAN		GROUP NUMBER		POLICY NUMBER			
TYPE OF PLAN OR COVERAGE HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER							
POLICY OWNERS NAME (GUARANTOR)		IPA		PRIMARY CARE PROVIDER			

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to William Moore Thompson IV, M.D., Inc. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to William Moore Thompson IV, M.D., Inc. . I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a $20.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

HEALTH HISTORY FORM

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

Personal Medical History: Have you ever had (please circle all answers Yes or No)

High Blood Pressure	No	Yes	Anxiety	No	Yes	Pneumonia	No	Yes
Heart Disease	No	Yes	Depression	No	Yes	Meningitis	No	Yes
Heart Murmur	No	Yes	Epilepsy	No	Yes	Enlarged Prostate	No	Yes
High Cholesterol	No	Yes	Osteoporosis/Osteoarthritis	No	Yes	Tremors	No	Yes
Diabetes, Type 1 or Type 2	No	Yes	Hyperthyroidism/Hypothyroidism	No	Yes	Seizures	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Urinary problems	No	Yes
Stomach pain or Reflux	No	Yes	Hives or Eczema	No	Yes	Blood in Urine	No	Yes
Kidney Stones	No	Yes	Migraines	No	Yes	Lupus	No	Yes
Kidney disease	No	Yes	Gallbladder Disease	No	Yes	AIDS/HIV	No	Yes
Neuritis or Neuralgia	No	Yes	Colitis or other Bowel Disease	No	Yes			
Bone or Joint disease	No	Yes	Jaundice or Liver Disease	No	Yes			
Sciatica, Back pain	No	Yes	Cancer *	No	Yes	* Type of Cancer: _____		

If you have, or have had, any symptoms in the following areas to a <u>significant degree</u>, please briefly explain.

Skin:	Back/Joints:	***Recent Changes in the following:***
Head/Neck:	Intestinal:	Weight:
Ears/Nose/Throat:	Bladder:	Energy level:
Lungs:	Menstruation:	Mood:
Chest/Heart:	Circulation:	Other pain or discomfort:

Other Medical Problems & Surgeries:

_____

_____

List All Current Medication/Dosages: (include non-prescription) Use back of page

_____

_____

Allergies to medications or food:

_____

Describe the allergic reaction:

_____

Do you drink alcohol?	No	Yes	Number of drinks _____ per week	Quit date: _____
Do you or have you ever smoked?	No	Yes	How many cigarettes per day: _____ Quit date: _____	How many years: _____
Do you use drugs?	No	Yes	What kind: _____	How many years: _____

Are you currently (circle one): Married Single Divorced Widowed

How many children do you have? _____ Ages: _____

Occupation: _____ Employer: _____ Highest level of education: _____

Please list the last date you had any of the following:

Pap Smear _____ Mammogram _____ Prostate Exam _____ Colonoscopy _____

Family Medical History: *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: _____ Paternal grandfather: _____

Mother: _____ Paternal grandmother: _____

Brother: _____ Maternal grandfather: _____

Sister: _____ Maternal grandmother: _____

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will schedule routine physical exams and other health maintenance exams recommended to me by my doctor (Pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see my doctor for immediate problems. I will make appointments with my doctor to discuss routine health screenings.
3. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
4. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments my physician may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
5. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
6. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
7. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
8. I will treat all providers and office staff respectfully and courteously.
9. I will fulfill my financial obligations for care provided to me in a timely manner.
10. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
11. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
12. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: _____ Date: _____

Signature: _____

MISSED APPOINTMENT POLICY

We would like to make you aware of our policy regarding missed appointments and or cancellations without sufficient time notice (preferably more than 24 hours).

We try to keep our patients scheduled in a timely manner. We know that your time is valuable; therefore, we don't double book appointments. When an appointment is given to you, the time is blocked off specifically for you. If you don't appear or cancel without sufficient time notice, it prevents us from trying to accommodate another patient, resulting in wasted time for the Doctor.

Therefore, if we are not given a sufficient time notice of an appointment cancelation or you simply do not show up for your appointment, we will have to charge you a fee of **$40.00.**

We understand that emergencies do happen, and adequate notice is not always possible. We do ask that you contact our office as soon as you realize that you will not be able to make your appointment or procedure, in order to avoid these charges.

As a courtesy, our EHR system tries to confirm appointments one week & two days prior. If you have any questions about your appointment day or time, we encourage you to call our office. **Please do not rely on the confirmation call to remind you of your appointment.**

Thank you for your cooperation and understanding. If you have any questions, we will be happy to assist you.

I have read the above policy and agree to comply with the terms and conditions stated.

Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

(The Notice of Privacy Practices provided by **Dr William Thompson IV** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Dr William Thompson IV reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Dr William Thompson IV 1501 Superior Ave. Suite 208 Newport Beach, CA 92663.**

With this consent **Dr William Thompson IV's Office or Associates** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Dr William Thompson IV's Office or Associates** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Dr William Thompson IV's Office or Associates** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that **Dr William Thompson IV's Office or Associates** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Dr William Thompson IV's Office or Associates** to use and disclose my PHI to carry out TPO.

I may 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, **Dr William Thompson IV's Office or Associates** may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Date	Relationship to Patient

_____	_____
Print Patient's Name	Print Name of Legal Guardian, if applicable

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing, I authorize **Dr William Thompson IV's Office or Associates** to use and/or disclose certain protected health information (PHI) about me to the following **FAMILY MEMBER/CAREGIVER**:

Name(s)/Relation: _____

Phone #: _____

This authorization permits **Dr William Thompson IV's Office or Associates** to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Dr William Thompson IV's Office or Associates.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Dr William Thompson IV
1501 Superior Ave. Suite 208
Newport Beach, CA 92663.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Legal Guardian, if applicable

Patient/guardian is entitled to receive a signed copy of this authorization form.

Good Faith Estimate

You have the right to receive a "Good Faith Estimate" explaining how much your medical and mental health care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.

You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Telehealth Consent

TELEHEALTH VISITS

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Doximity,Blue Google Duo, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Additionally, in **RARE circumstances** security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

I do hereby consent to allow my provider to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits. You will be notified in advance if a recording is necessary.

I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation, and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

I understand that I have a right to request copies of such recordings and have the right to revoke this authorization in writing at any time during the course of my treatment.

I understand that this authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian, if applicable

Patient/guardian is entitled to receive a signed copy of this authorization form.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVV _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon visits. I understand that my information will be saved to file for future transactions on my account.

I authorize Dr. William Moore Thompson IV to charge my credit/debit/health account card for professional services 24 hours following our scheduled appointment. If I do not cancel before 24 hours, I recognize that Dr William Moore Thompson IV will charge my card as a late cancel or no show if I do not show up for the appointment.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

_____ _____

Customer Signature Date