Thornton Plastic Surgery

Joseph J. Thornton, MD

Name_____ Date_____

Address_____City/State/Zip_____

Home Phone_____Cell Phone_____Preferred **Home/Cell**

Email_____DOB_____ Age_____

SSN_____ Circle **Married/Single/Other** Sex: **M/F** Dominant hand: **Left/Right**

Race_____ Ethnicity_____ Language_____

Referred By Doctor_____Friend_____Med-Aid/ER_____

Employer_____Occupation_____

Employer's Address_____ Work Phone_____

Spouse/Sig. Other_____Contact #_____

Pharmacy_____ Pharmacy Phone_____

Family Doctor_____ Office Phone_____

Reason for Consultation_____

Height_____ Weight_____ Weight Gain/Loss (time frame)_____

Smoking History **Never** **Active** **Prior** Age Started_____ Ended_____ Packs Per Day_____

List All Drug **ALLERGIES** (Including Latex)

Drug	**Reaction**	**Drug**	**Reaction**

Current **MEDICATIONS** (Include Aspirin & Supplements)

Medication	**Dosage**	**Medication**	**Dosage**

Past **SURGERIES** with Dates

Skin Cancer/Lesion History Note if you've previously had any of the following and location/date(s) treated

Actinic Keratosis (pre-cancer)	
Basal Cell Cancer	
Squamous Cell Cancer (of skin)	
Dysplastic Nevus (abnormal mole)	
Melanoma	

Medical History **Family History** Use **M-**Mother **F-**Father **S-**Sibling **C-**Child

Personal History	**Yes**	**No**	**Explain**	**Family History**	**Yes**	**Who**	**Explain**
Anemia				Adopted			
Asthma				Abnormal Bleeding			
Bleeding Disorder				Abnormal Clotting			
Breast Cancer				Autoimmune Disorder			
Depression/Anxiety				Brain Tumor			
Diabetes				Breast Cancer			
DVT/PE				Colon Cancer			
Heart Disease				Diabetes			
Hepatitis				Endocrine Disease			
High Blood Pressure				Heart Disease			
High Cholesterol				High Blood Pressure			
HIV				Hemophilia			
Kidney Disease				Kidney Disease			
Liver Disease				Liver Disease			
Pacemaker/AICD				Lung Cancer			
Poor Circulation				Malignant Melanoma			
Psychiatric Care				Ovarian Cancer			
Respiratory/COPD				Prostate Cancer			
Skin Cancer				Skin Cancer			
Skin Disease				Thyroid Disease			
Stroke				Other Cancer			
Substance Abuse				Von Willebrand			
Thyroid Disease							
Other:							

Date of Last Mammogram_____ Normal_____ Abnormal_____ Bra Size (if breast related visit) _____

Are you pregnant? **Yes/No** Are you trying to get pregnant? **Yes/No**

Vaccinations: Influenza **Yes/No** Pneumococcal **Yes/No** Covid-19 **Yes/No**

Do you exercise and maintain a healthy diet?_____

Alcohol Use **None** **Social** **Everyday** Frequency/type_____

Drug Use **None** **Social** **Everyday** Frequency/type_____

<u>Review of Systems</u> Please Circle Each Item "YES" or "NO" as They Relate to Your Health:

Constitutional				**Genitourinary**		
Unplanned Weight Loss	Yes	No		Burning/Frequency	Yes	No
Fever	Yes	No		Blood in Urine	Yes	No
Chills	Yes	No		**Hematology/Lymph**		
Eyes:				Easy Bruising	Yes	No
Glasses/Contacts	Yes	No		Enlarged Glands	Yes	No
Double Vision	Yes	No		**Musculoskeletal**		
Cataracts	Yes	No		Joint Pain/Swelling	Yes	No
Ear, Nose, Throat				Muscle Pain	Yes	No
Difficulty Hearing	Yes	No		**Skin**		
Sinus Trouble	Yes	No		Rash/Sores/Itching	Yes	No
Nasal Stuffiness	Yes	No		Lesions	Yes	No
Cardiovascular				Tears Easily	Yes	No
Chest Pain	Yes	No		**Neurological**		
Murmur	Yes	No		Numbness	Yes	No
Fainting Spells	Yes	No		Weakness	Yes	No
Difficulty Lying Flat	Yes	No		Headaches	Yes	No
Palpitations/Heart Racing	Yes	No		**Endocrine**		
Respiratory				Loss of Hair	Yes	No
Cough	Yes	No		Heat/Cold Intolerance	Yes	No
Wheezing	Yes	No		**Allergic/Immunologic:**		
Shortness of Breath	Yes	No		Hives/Eczema	Yes	No
Gastrointestinal				**Psychiatric**		
Heartburn/Reflux	Yes	No		Anxiety/Depression	Yes	No
Abdominal Pain	Yes	No		Difficult Sleeping	Yes	No
Constipation	Yes	No		Mood Swings	Yes	No

Insurance/Billing Information

Primary Insurance Company_____Phone_____

Claim Address_____Id#_____Group#_____

Subscribers Name_____ SS#_____Birth Date_____

Secondary Insurance Company_____Phone_____

Claim Address_____Id#_____Group#_____

Subscribers Name_____ SS#_____Birth Date_____

Workers' Compensation

Name of Employer_____Supervisor/Manager_____

Mailing Address_____Phone_____

How Injury Occurred_____

Date of Accident_____ Date Reported to Employer_____

Claim number if available_____

Auto Accident

Name of Auto Insurance Company_____Phone_____

Complete Claim Address_____

Adjuster's Name_____Date of Accident_____

Patient Photo Release Form

- I understand that photographs **may/will** be taken for documentation and providing appropriate follow up and care in the treatment of your condition by the doctor. These photos will be maintained in your Electronic Health Record.
- Photographs are often utilized in our field for both educational and marketing purposes.
- By signing this form, the patient affirms in understanding that images may be used for additional reasons indicated.
- You agree that you will not receive any form of compensation in cash or in kind.
- You likewise understand that your name will NOT be included in the images and faces will NOT be shown in body photography. Nonetheless, it is still possible that someone may recognize you.
- Your refusal to consent to the **RELEASE** of your photographs will NOT, in any way affect your medical care.
- You may rescind your authorization to the release of the photographs by writing us a request.

I hereby authorize the use of Photographs for the following:

❒ **Educational Purposes** such as Medical Procedure Demonstration, Conferring with Colleagues

❒ **Website Gallery**

❒ **Social Media** and Online Publishing ads

❒ **Print** Marketing Advertisements

❒ **Video** and Television Media Advertisements

Patient_____ Witness_____

Financial Policies

- **Co-Pays and Deductibles and Insurance** **Initial _____**

We try our best to inform you of your insurance benefits prior to your appointment. If we are "in network" benefits are paid at the contracted rate, less co-pays or deductibles that you may have. For patients "out of network" we are happy to submit your claim, though payments vary and you will be responsible for any uncovered portion of your bill.

Patients are expected to present an insurance card at each visit. All co-payments and deductibles are due at time of service, unless prior arrangements have been made. We accept cash, check, debit and credit cards (American Express, Discover, MasterCard or Visa) as well as Care Credit. If you are unable to make payment, the appointment may be rescheduled. We are always happy to prepare an estimate for you. **Ultimately YOU are responsible for your bill.**

- **Referrals and Pre-Authorizations** **Initial _____**

If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. We are available to assist you, but failure to obtain the referral and/or pre-authorization may result in you being held responsible for the entire bill. **Ultimately YOU are responsible for your bill.**

- **Statements** **Initial _____**

All balances are due upon receipt of billing statement. If you need to make payment arrangements, please contact us immediately. We are happy to work with you. Please understand that paying in a timely fashion is required or you may be discharged from the practice. Financial hardship may be considered.

- **Returned Checks** **Initial _____**

The charge for a returned check is $40. This will be applied to your account in addition to the insufficient funds amount. If insufficient funds are not paid within 15 days, the amount will be sent to collections.

- **Financial** **Initial _____**

Balances that are not paid within 60 days either by insurance or the patient become the **SOLE** responsibility of the patient. In the event of default of payment and/or failure to pay, you are responsible to pay the costs of collection including original balance and any additional fees accrued from the collections agency.

- **Self-pay Accounts** **Initial _____**

Self-pay accounts are patients without insurance coverage, patients with insurance plans in which the office does not participate, or patients without an insurance card on file. You will be expected to pay in full at the time of service and will receive a 25% discount. Certain insurance plans may not allow us to treat you as a self-pay patient for medical services rendered. If we cannot see you at our office, we will help you find another office that can.

- **Cosmetic vs Insurance Procedures** **Initial _____**

Coverage of certain medically necessary procedures (breast reduction, skin removal, blepharoplasty) which are "cosmetic" in nature, may be requested from your insurance. Even if the procedure is not covered; if it is to be "submitted to insurance" an appropriately documented and billed visit will be created and you will be responsible for any insurance co-pay or deductible.

- **Cosmetic Consultations** **Initial _____**

While consultations remain **FREE** at our practice, **a 50$ scheduling fee is charged for each cosmetic consultation, it's non-refundable**. This fee will be refunded if surgery is scheduled.

- **Minors** **Initial _____**

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A **signed release** to treat will be required for an unaccompanied minor. Patients over the age of 18 are responsible for any balance due.

- **Worker's Compensation/Personal Injury/Motor Vehicle Accidents WC/PI/MVA** **Initial _____**

We will submit claims to your insurance for WC/MVA, however, if payment is not made, you will be fully responsible for your bill. For PI you will be responsible to pay as you go and get reimbursed through your insurance/attorney.

I authorize Dr. Thornton to treat me or my child by accepted medical practice and assign payment of my medical benefits to Dr. Thornton as well. I understand the above policies and have had the opportunity to ask questions

Signature _____Date_____

HIPAA and Privacy

Dr. Thornton and his office staff may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). I authorize them to call me and leave a message on voice mail to assist the practice in carrying out TPO. This includes but is not limited to appointment reminders, insurance questions, clinical care, laboratory/pathology/radiology results, etc.

Under the requirements of HIPAA we are not authorized to discuss any medical or billing issues with anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must identify them below.

You may rescind your authorization to the release of the information by writing us a request.

I understand the above guidelines and have had the opportunity to ask any questions. The notice of privacy practices was made available to view and is available on the website www.thorntonplasticsurgery.com

Patient_____ Witness_____

I, _____ authorize Dr. Thornton to release my medical and/or billing information to:

_____Relationship to Patient: _____

_____ Relationship to Patient: _____

_____ Relationship to Patient: _____

Patient _____ Witness_____

Leaving Messages with Family/Voicemail

At times it is necessary to leave messages for patients. The purpose of these messages may be regarding appointments, to notify the patient of test results, or to ask a patient to call regarding an issue or concern. At no time will a member of Thornton Plastic Surgery discuss your medical condition without your consent. This consent allows us to leave messages with members of your household or on your voicemail.

You may rescind your authorization to leave messages by writing us a request.

Signed_____ Date: _____

The End! You made it!!