

Joseph J. Thornton, MD

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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			
Bleeding Disorder				Abnormal Bleeding			
DVT/PE				Abnormal Clotting			
Diabetes				Von Willebrand			
Organ Transplant				Hemophilia			
Heart Disease				Autoimmune Disorder			
High Blood Pressure				Diabetes			
High Cholesterol				High Blood Pressure			
Pacemaker/AICD				Heart Disease			
Poor Circulation				Endocrine Disease			
Asthma				Kidney Disease			
Respiratory/COPD				Liver Disease			
Stroke				Breast Cancer			
Thyroid Disease				Skin Cancer			
Cancer				Malignant Melanoma			
Breast Cancer				Other Cancer			
Prostate Cancer							
Kidney Disease							
Liver Disease							
Hepatitis							
HIV							
Depression/Anxiety							
Psychiatric Care							
Substance Abuse							
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**

Alcohol Use **None** **Social** **Everyday** Frequency/type _____

Drug Use **None** **Social** **Everyday** Frequency/type _____

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

Constitutional				Genitourinary		
Unplanned Weight Loss	Yes	No		Blood in Urine	Yes	No
Eyes:				Hematology/Lymph		
Cataracts	Yes	No		Easy Bruising	Yes	No
Ear, Nose, Throat				Enlarged Glands	Yes	No
Difficulty Hearing	Yes	No		Musculoskeletal		
Difficulty Swallowing	Yes	No		Joint Pain/Swelling	Yes	No
Cardiovascular				Muscle Pain	Yes	No
Chest Pain	Yes	No		Skin		
Fainting Spells	Yes	No		Rash/Sores/Itching	Yes	No
Palpitations/Heart Racing	Yes	No		Neurological		
Respiratory				Numbness	Yes	No
Shortness of Breath	Yes	No		Weakness	Yes	No
Gastrointestinal				Psychiatric		
Heartburn/Reflux	Yes	No		Anxiety/Depression	Yes	No
Abdominal Pain	Yes	No		Mood Swings	Yes	No

Insurance/Billing Information

If you have the insurance cards and are the subscriber; LEAVE BLANK and PROVIDE YOUR CARDS.

Primary Insurance Company _____ Phone _____

Claim Address _____ Id# _____ Group# _____

Subscribers Name _____ Birth Date _____

Secondary Insurance Company _____ Phone _____

Claim Address _____ Id# _____ Group# _____

Subscribers Name _____ 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 _____

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 the 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 _____

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. We accept cash, check, debit and credit cards as well as Care Credit. If you are unable to make payment, the appointment may be rescheduled. We are happy to prepare an estimate. **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 as we will 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 – Non-Cosmetic/Medical Procedures** 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. 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”, may be requested from your insurance. Even if the procedure is not covered; if it is “submitted to insurance” an appropriately documented and billed visit is created and you will be responsible for any insurance co-pay or deductible.

- **Cosmetic Consultations** Initial _____

Consultations remain **FREE** at our practice, however, a **\$100 scheduling fee** may be charged. This will secure your appointment time.

- **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** _____