James P. Thomas, M.D. | voicedoctor.net
Physician & Surgeon – Practice Limited to Laryngology

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Completion of this information in its entirety is required at time of first visit

PATIENT (USE INK ONLY—please)

Mr Ms Mrs Miss ____
First Middle Last

Address ____
Street City State ZIP

Home Phone (______) _______—___________ Work Phone (_______) _______—___________ Social Security # _______/____/_______
(required for payment purposes in granting credit for office appointment charges)

Birth Date ____ / ____ / _______ Gender M F Cell Phone (_______) _______—___________ Fax (_______) _______—___________

Marital Status: Single Married Partnered Widowed E-mail address ______________________________
Is it okay to use your e-mail address for medical correspondence? ☐ yes ☐ no

Employer ______________________________Occupation ______________________________

How were you referred to this office? ______________________________ Primary Care Physician ______________________________

If someone other than patient is RESPONSIBLE FOR PAYMENT, complete the following:

Name of **responsible party** ______________________________Address ______________________________

Relationship ______________________________ Social Security # _______/____/________ Home Phone (_______) _______—___________

Employer ______________________________ Occupation ______________________________ Work Phone (_______) _______—___________

In case of emergency contact person and phone number ______________________________

What will be the FORM OF PAYMENT for your care?

_______ Cash, check or credit card at time of service ________ Dr Thomas will bill health insurance for you; you will pay copay at the time of service

A valid, current insurance card is *required* at the time of service so that we may adequately assist you in billing your insurance.

Primary insurance ___________________Subscriber_____________________ DOB: ____ / ____ / _______ SSN: _______/____/_______

Subscriber, if not patient ______________________________ Relationship to patient ______________________________

Secondary insurance ________________Subscriber______________________ DOB: ____ / ____ / _______ SSN: _______/____/_______

Subscriber, if not patient ______________________________ Relationship to patient ______________________________

If you are insured through any Medicare type insurance plan, your insurance requires us to ask you the following question. Please simply check the appropriate response – *Have you filled out an Advanced Directive?* (Please check response) ☐ yes ☐ no

HIPAA (Health Insurance Portability and Accountability Act) of 1996 Requirements for Acknowledgement and Consent

Please INITIAL the following boxes:

☐ **(treatment authorization)** I authorize the office of James P Thomas MD LLC to use and disclose my health and medical information for the purposes of TREATMENT*, PAYMENT* and HEALTH CARE OPERATIONS.*

*TREATMENT (includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care, coordinating or managing care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my practice by telephone as the on-call physician.)

*PAYMENT (includes activities involved in determining eligibility for health plan coverage, billing and receiving payment for health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.)

*HEALTH CARE OPERATIONS (includes the necessary administrative and business functions of this office).

☐ **(education)** I agree to allow the use of photos or video recordings of my voice/vocal cords to the public such as in speeches, videotape or internet for educational purposes. The use will be anonymous. I understand examples of the type of use may be found on www.voicedoctor.net.

☐ **(research)** I consent to the use of my medical data (anonymously) for use by Dr. Thomas in medical research and publications.

OVER

☐ (**Privacy Act**) I acknowledge I will be provided an opportunity to read the NOTICE OF PRIVACY PRACTICES of this office, which provides a more complete description of information uses and disclosures. I understand I can review it at any time in the future and may obtain a copy at my request. I understand that this office reserves the right to change the notice and practices and will post them in the office.

☐ (**restriction of information**) I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this office is required to agree to the restrictions requested.

☐ (**leaving messages**) I give permission for James P Thomas MD LLC to leave appointment reminder messages or messages to contact the clinic at my home phone number, work phone number, or mobile phone number.

☐ (**right to revoke consent**) I understand I have the right to revoke this CONSENT, provided I do so in writing, and that this consent will remain in effect until revoked.

I agree that charges not paid directly by my insurance company will be my responsibility. If it becomes necessary to effect collection of an amount owed on this or subsequent visits, the undersigned agrees to pay for all expenses, including reasonable attorney fees. If a referral is necessary for care, I will participate in obtaining one.

Please sign below.

Signature ____ Date _________________________

If other than patient, relationship to patient ____

Any non-sufficient funds checks are subject to a surcharge to cover our banking costs. Thank you.

Updated Signature and Date

Patient information has been reviewed for accuracy and corrected as of this date: