112 E. Luellen Road, Hinton, OK 73047 – P: 833.274.4174 - F: 833.274.4175

Trey Thomason, D.O.

PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ____ Single _____ Married _____ Widowed _____ Divorced _____Separated
Patient's Address:	Employment Status: ____ Employed _____ Full-time student _____ Part-time student _____ Retired

City:	State:	Zip Code:	Patient Employer:

Home Phone:	Work Phone:	E-Mail Address:

Cell Phone: _____ Is it ok to leave a message at the number provided? Yes _____ No

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim.

Name of Primary Insurance Company

Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

Secondary Insurance (if applicable)

Policyholder Name	Relationship to Patient
Policyholder DOB	Policyholder SSN
Policyholder Employer	

PERSON RESPONSIBLE FOR BILL

Name	DOB	SSN

Address (if different from patient)	Phone Number

EMERGENCY CONTACT

Name:	
Contact Number:	Relationship to Patient:

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Trey Thomason, D.O. has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Date: _____

HPI NORTHWEST SURGICAL HOSPITAL
HPI COMMUNITY HOSPITAL
HPI COMMUNITY HOSPITAL IMAGING CENTER
HPI COMMUNITY HOSPITAL OUTPATIENT THERAPY
HPI NORTHWEST SURGICAL HOSPITAL LAKEPOINTE IMAGING CENTER

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Authorization to Release Information via phone/Family/Friends

Patient Name: _____ DOB: _____

I hereby authorize confidential communications from the physicians or staff of Thomason Medical Clinic regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home Phone: _____ Work Phone: _____ Cell phone: _____

Other: _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

I understand this authorization will remain in effect until I revoke the authorization in writing. I also understand that this does not authorize the above persons' consent to treat a minor unless they are a parent or guardian, or unless they are listed on the Consent and Authorization to Medical Care for A Minor form.

_____ _____

Patient or Legal Guardian Signature Date

Thomason Medical Clinic, LLC STAFF ONLY:

Documented by:

Initials: _____ Date: _____

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CONSENT AND AUTHORIZATION TO MEDICAL CARE FOR A MINOR

(Please fill out for all minors – write "none" and sign if there is no one outside of a parent or guardian that is authorized to bring your minor in for treatment.)

The undersigned hereby authorize _____, _____, _____, _____ (NAMES) to seek and obtain medical care and treatment for:

_____ (MINOR NAME)
_____ (MINOR DATE OF BIRTH)

that is recommended by Thomason Medical Clinic and Trey Thomason, D.O. and the undersigned do hereby consent to such medical care.

Furthermore, the undersigned agree to pay the costs of any medically necessary medical care that is provided in reliance on this Consent and Authorization.

Medical care, as used in this Consent and Authorization includes, without limitation, any medical care reasonably necessary to treat any illness, injury, disease, symptom or ailment and includes diagnosis, treatment, surgery and other medical care such as vaccinations, xrays, ultrasounds, lab draws, etc.

It is intended that this Consent and Authorization will continue in effect for a period of up to 1 year from the date signed. However, should this period be extended for any reason, this Consent and Authorization will continue in effect.

A photocopy of this Consent and Authorization may be considered to be, and utilized as, an original.
The undersigned are the natural parents and/or legal guardian of the minor.

Signed this _____(DATE) .

_____
PARENT/GUARDIAN

ADDITIONAL INFORMATION RELATED TO MINOR CHILD (if applicable):
Known Allergies: _____
Present Medications: _____
Insurance/Payor:_____

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OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Date of Birth:_____

Medical Record #:_____ Social Security #:_____

Please list any previous/current doctors and/or hospitals that you authorize to send Thomason Medical Clinic your Medical records:

_____

(Name and address of person/organization receiving PHI)

Information you are willing to share with Thomason Medical Clinic: (check all that apply)

___ Psychotherapy notes (if checking this box, no other boxes may be checked) ___ Entire medical record

___ Billing information for _____ ___ Mental health records

___ Substance abuse records ___ Medical information compiled between ___ and ___

___ Other: _____

The information may be disclosed for the following purposes only:

___ Insurance ___ Continued treatment ___ Legal ___ At my or my representative's request

___ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

Signature of Patient or Legal Representative_____

Description of Legal Representative's Authority _____

Date : _____ Expiration date: (if longer than one year from date of signature or no event is indicated) _____

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MEDICATION REFILLS

1. Refill requests may be made Monday-Thursday, 8:00 am to 4:00 pm. Please have the pharmacy fax refill requests to 405-542-2281.

2. Refills will not be made after hours, at night, on weekends or holidays. On call physicians will not answer calls regarding medication refills.

3. All prescriptions require a 3-5 day notice to be refilled.

4. Please check your bottles for refills. If you have refills you do not need to call the doctor's office, only call the pharmacy.

5. Patients are responsible for their controlled substance medication. Your doctor will closely monitor controlled substance medication.

6. Please remember to discuss any medication concerns you have with your doctor at your regular scheduled appointments.

7. Our office hours are Monday-Friday, 8:00 am to 4:30 pm.

8. After hours or in case of emergency, you may call 405-542-2278 and you will be given instructions on how to contact the doctor on call.

Patient signature: _____ Date:_____

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Appointment No Show and Late Policy

APPOINTMENT NO SHOWS

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.
- The second no show will result in a call or email and a **$25.00** charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.
- The third no show will result in a dismissal from the practice.

LATE POLICY

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment time, we will then give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Any patient arriving more than 10 minutes late will be asked to reschedule.

Signature of patient: _____

Print name of patient: _____

Signature of parent/guardian (if applicable): _____

Print name of parent/guardian: _____

Dated: _____

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PHOTO/VIDEO CONSENT AND RELEASE FORM

Patient Name: _____ Date of Birth _____

I consent for photographs and/or video images to be taken of me by Thomason Medical Clinic or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching, training, and/or for marketing purposes (website, print, digital, or social media).

By consenting to photographs and/or video images, I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever. Refusal to consent to photographs and/or video images will in no way affect the medical care I will receive.

I authorize the use of photographs and/or video images: (please INITIAL indicating YES or NO)

_____YES _____NO For educational purposes (medical teaching or training)

_____YES _____NO For marketing/advertising purposes (website, print, digital, or social media)

_____YES _____NO At my request, my photographs and/or video images will only be used as part of my medical record.

I hereby release Thomason Medical Clinic, its employees, and any third parties involved in the creation or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm that this consent form has been explained to me in terms which I understand. If I wish to withdraw my consent in the future, I may do so via written request submitted to Thomason Medical Clinic or by completion of a new form.

Patient/Legal Guardian Signature: _____ Date: _____