Patient Registration
Scott Thornton, Ph.D.

Date:_____ Acct.#:_____

Patient Name:_____ SS#:_____-_____-_____
Last First Middle Initial

Home Address:_____ _____
Apt. No.

Sex: ☐ F _____
☐ M City State Zip Code

Home Phone: ( )_____ Date of Birth:_____/_____/_____ Age:_____

Race: ☐White ☐Black ☐Hispanic ☐Native American ☐Other:_____

Employed: ☐ Yes ☐ No Student: ☐ Yes ☐ No

Employer: _____ Occupation:_____

Address:_____ Wk. Phone: (____)_____x_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Referral Source:_____ Specialty:_____Phone: (____)_____

Emergency Contact: _____

Phone: (____)_____ Relationship to Patient: _____

Responsible Party: _____

Patient Relationship to Responsible Party: ☐ Self ☐ Husband ☐ Wife ☐ Child ☐ Other

Spouse's Name:_____ Spouse's Date of Birth:_____/_____/_____
Last First

Spouse's Employer:_____

Spouse's Work Phone: (____)_____x_____ Spouse's SS#: _____-_____-_____

Is Patient a Minor? ☐ Yes ☐ No ****IF YES, FILL OUT PARENT INFORMATION****

Parent(s) Name:_____ Date of Birth:_____/_____/_____
Last First

Address: _____ SS#: _____-_____-_____

City: _____ State: _____ Home Phone: (____)_____

Employer: _____ Work Phone: (____)_____x_____

Insurance Information

Primary Insurance Carrier: _____

ID#: _____ Group Name / Number: _____

Policy #: _____ Ins. Co. Phone #: (____)_____

Insured Party Information (**If other than Patient**):

Name: _____ Date of Birth: _____/_____/_____

Address: _____

SS#:_____-_____-_____ Insured's Employer: _____

Patient Relationship to Insured: _____ Effective Date: _____

Secondary Insurance Carrier: _____

ID#: _____ Group Name / Number: _____

Policy #: _____ Ins. Co. Phone #: (____)_____

Insured Party Information (**If other than Patient**):

Name: _____ Date of Birth: _____/_____/_____

Address: _____

SS#:_____-_____-_____ Insured's Employer: _____

Patient Relationship to Insured: _____ Effective Date: _____

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May we contact you by phone for appointment reminders? Home: □ Yes □ No

Work: □ Yes □ No

May we contact others regarding financial information and/or medications?

Name of Contact:_____

Relationship of Contact to Patient: □ Spouse □ Child □ Parent(s) □ Other_____

KINDLY GIVE 24-HOUR ADVANCE NOTICE if you are unable to keep your appointment, **OR YOU WILL BE CHARGED FOR THE RESERVED TIME.**

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_____ _____

Signature of Patient / Parent / Guardian **Date**

IF PATIENT IS A MINOR, PARENT OR GUARDIAN MUST SIGN

Assignment of Insurance Benefits
Scott Thornton, Ph.D.

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Patient Name (please print) _____

Insurance Company _____

☒ **Consent to Release Claims Information and Assignment of Benefits:**

I authorize the payment of medical benefits for services rendered to me (or the patient) directly to Scott Thornton, Ph.D.

I hereby consent for Scott Thornton, Ph.D. or any of his employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency, their employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.

I understand insurance billing is a service provided as a courtesy, and that I am at all times personally responsible for any fees not covered by my insurance carrier. Should any insurance payment be made directly to me or to the insured for monies due on this account, I agree to immediately pay over these funds to Scott Thornton, Ph.D. I also acknowledge I am responsible for any deductible, copay, or other balance not covered by my insurance carrier.

☐ **Medicare:**

Name of Patient _____ Medicare ID # _____

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Scott Thornton, Ph.D., including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Patient signature Date
(Parent or Guardian's signature if patient is under 18)

_____ _____

Guarantor's Signature Date

_____ _____

Witness' Signature Date

Rev 1/22/04 nrk

Office Policy
Scott Thornton, Ph.D.

Welcome to my practice. I am committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of my financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your treatment. In an effort to keep medical costs down while maintaining a high level of professional care, I have established the following office policies. Please read carefully and sign at the bottom of the second page indicating your understanding and acceptance of my policies and procedures.

Appointments:

My office hours are 8:00am to 12:00pm, and 1:00pm to 5:00pm daily. My office closes during the lunch hour. Patient appointments are scheduled Monday through Friday. You can schedule an appointment by calling during regular office hours.

Financial Policy:

1. Payment is due at time of service. Payment may be made by cash, check, Visa, MasterCard, Discover, or American Express.
2. Patients are responsible for their co-payments and/or deductibles at the time services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's).

Billing:

A statement covering all services rendered up to the date on the statement will be mailed on a monthly basis and will reflect the current balance. Payment is due upon receipt of statement.

Insurance:

If you have insurance, I will be happy to help you determine the coverage you have available. Your insurance policy, however, is a contract between you and your insurance company. I, therefore, cannot guarantee payment of your claims or accept responsibility of negotiating claims with insurance companies or other persons. It is the ultimate responsibility of the patient to understand his/her insurance coverage. Insurance policies may change and/or insurance company representatives do not always give me correct or consistent information. ***In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered.*** If payment from your insurance carrier is not received within forty-five (45) days, I will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information become your responsibility after thirty (30) days. I encourage you to become familiar with your particular insurance benefit plan and philosophy of its administration.

Your method of health care delivery may be through a system of "managed health care." Under this type of health care delivery system, the physician is not the sole person making determinations about your clinical care. The insurance carrier may also have reviewers who make treatment recommendations to the physician and who help the physician work within the particular guidelines and limitations of the insurance plan and managed care company. On occasion, the physician's clinical recommendations may be different from these various managers and reviewers. It is your responsibility to know what the limitations of your insurance policy are, and if the limitations of your insurance policy are exceeded, you will be responsible for any costs unless otherwise agreed upon by contract between the doctor and my insurance plan administrators.

Scott Thornton, Ph.D. does not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.

Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts) must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Miscellaneous Charges:

There will be a charge for reproduction of medical records and report preparation. Fees for medical records are $25.00 for the first 20 pages, and $.15 for each page thereafter. Report preparation fees are based on the time involved.

Any returned checks are subject to a $30 service fee. Any returned check must be resolved before any future appointments can be arranged.

Scott Thornton, Ph.D. contracts with Xelco collection agency, to collect delinquent accounts. Once an account is placed with Xelco, the patient must deal directly with Xelco for payment of the account. In the event of account placement with Xelco, the applicable collection fees will be added to that account. Currently, these additional fees are equal to 25% of the total balance owed. Therefore, prompt payment is encouraged.

Missed Appointments:

Please realize that it is each individual's responsibility to keep track of appointments made. If you need to cancel an appointment, please give me 24 hours notice so that we may schedule another patient in the time slot reserved for you, or you will be charged. In the event that you do not receive a courtesy reminder call, please realize it is your responsibility to keep track of your appointments. ***If you do not cancel your appointment 24 hours in advance, our policy is to charge the rate of a normal office visit ($90) regardless of your insurance status and is payable prior to future visits.*** These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

Refill Requests / Messages:

All requests for prescription refills must be made 48 hours in advance in order to sure the necessary paperwork and/or signatures required can be completed. You must have your pharmacy call to give us your refill information. Please remember to check with your pharmacy before picking up your refill to ensure that your prescription is ready. Any phone messages left on our voice mail system after 3:00pm will be returned the next business day. In the event that you call our office and your clinician is out that day, your call will be returned the next business day. If you feel that your call needs emergency attention, please contact our main phone number at: 972-566-4591.

Emergency Situations / After Office Hours:

Medical emergencies, psychotherapy and the scheduling or canceling of appointments cannot be handled appropriately by telephone. Medication refills are only addressed during office hours. For urgent matters after 5:00 PM, a physician is on call. In an emergency, call 911 or go directly to the nearest emergency room.

Thank you for understanding my office policy. This has become necessary in order to accept insurance plans without having patients pay the balance up front and then wait themselves for reimbursement from their insurance company. Our goal is to make your visit with us pleasant and professional. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your care. ***Please remember, missed office visits will be charged if you do not cancel your visit 24 hours in advance.***

I have read and understand pages 1 and 2 of the Office Policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by Scott Thornton, Ph.D.

_____

Patient Name (please print)

_____ _____

Signature of Patient/Parent/Guardian Date