Name: ____ Date of Birth _____________

SS#:____________________________________ Marital Status:____________________

Address______________________________City_________________State______Zip_________

Phone#__________________ Cell Phone# ____________________Work#__________________

Preferred method of contact: ☐ home phone; ☐ cell phone; ☐ text message; patient portal

Emergency contact name_____________________relationship___________Phone#______________

Email Address (this is necessary for access to TeleVisits and your Patient Portal): ______________________________

Primary Insurance: ______________________ Policy # ___________________
Secondary Insurance: ____________________ Policy # ___________________
In whose name is your insurance policy if someone other than yourself?
Insured's name_______________________________DOB_____________SS#__________________

Please provide a copy of your insurance card(s) and your driver's license to the receptionist.

Authorizations: For each question check Yes or No, then sign below

	Yes	No
• I have access to the Notice of Privacy Practice from Third Coast Family Practice (posted).	___	___
• I authorize Third Coast Family Practice to leave messages regarding appointments/results.	___	___
• I authorize Third Coast Family Practice providers and care manager to examine me and render medical treatment deemed necessary for evaluation, management and treatment of my medical and behavioral health conditions.	___	___
• I authorize the providers to submit claims to my insurance company and be paid for these services.	___	___
• I understand I am financially responsible according to the Payment Policy that I have read and signed.	___	___
• Our office subscribes to a pharmacy service that allows us to see what medications are covered by your insurance. In addition, this service gives us access to your prescription history. Do we have your permission to see this information?	___	___

- What is the name of your preferred Pharmacy? ____________________________

Are there persons with whom we can discuss medical information, test results, or appointment information?
If yes, identify their names, birth date, and your relationship to him/her. Yes____ No____

Name__________________________DOB__________Relationship__________________Phone Number__________

Name__________________________DOB__________Relationship__________________Phone Number__________

Name__________________________DOB__________Relationship__________________Phone Number__________

Patient's signature:____ Date: _________________

Third Coast Family Practice
Craig Matheson, D.O.

Payment Policy

1. Insurance: As a courtesy to our patients, all insurance companies will be billed if you have provided us with the information to do so. Please contact your insurance company with any questions you may have regarding your coverage and to verify that our services are In-Network for your policy. A list of insurances with which we participate can be found on our website; if we contract with your insurance, then we agree to accept their discounted fee schedule. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your account is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

2. Co-Payments and Deductibles: Co-payments and deductibles are expected at the time of service. Copayments not paid within 2 weeks of an office visit may incur a $10 service charge.

3. Non-covered Services: Please be aware that some and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Patients are responsible for non-covered charges.

4. Self Pay Patient Accommodations:
   - A 15% discount will be granted if payment in full is received on the day of service.
   - At your 1st new patient visit, a minimum deposit of $100 or the actual charges, whichever is less, is expected prior to being seen.
   - If you cannot pay in full, you may request a payment plan of monthly installments.

5. Proof of Insurance: Patients are required to provide a copy of their current insurance card and a photo ID for our records. Patients agree to keep this information current.

6. Patient Balances: Monthly statements will be mailed to you. Payment is expected within 30 days. If you cannot pay in full, please contact our office manager. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full or the account will be turned over to an outside collection agency. A 32% collection fee will be added to the balance of the account. Please be aware that an unpaid balance can lead to dismissal of you and your immediate family members from this practice. If this occurs, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will refill your prescriptions and treat you on an emergency basis only.

7. Fees: The following fees will be assessed:
   - FORMS- A $10 fee is required for completing forms in between office visits.
   - LETTER – A $25 fee is charged for letters written at patient's request by the provider.
   - COPAY SURCHARGE- A $10 fee for failure to remit copay.
   - LATE PAYMENT- $5 fee for each 30 day period in which balance is not paid in full.
   - CHECKS RETURNED FOR NSF: $25.00
   - COLLECTIONS- 32% fee added to accounts sent to collections.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have questions or concerns.

I have read and understand the payment policy, and agree to abide by its guidelines:

____________________________________ ______________________

Signature of Patient or Responsible Party Date

New Patient Health History Form

PLEASE NOTE: We are not accepting NEW Medicaid Patients at this time

Name:____DOB:_________________

Race: ________________________ or Decline to specify

Primary Language: English ____ Spanish ____ Other: ___________________

Gender Identity:

Male ___Female ___Transgender _____Other __________________

What was your gender assigned at birth? Male ___ Female ___

Sexual Orientation:

Do you consider yourself: heterosexual____ bisexual____ homosexual ___ other ______

Medication **allergies** please list medication and reaction:

____

List of **current medications** with dosage and frequency per day: List on back of this sheet.

Medical History: Do you have or have you ever had the following? (Please circle all that apply)

Arthritis	Artificial joints	Asthma	**Adult immunization dates:**
Cancer	COPD	Diabetes	Last Tetanus: ________________
Glaucoma	Heart disease Stroke	High cholesterol	Last pneumonia shot: __________
Hypertension	Implants(breast/other)	Pacemaker	Last Flu shot: ________________
Seizures	Thyroid disease	Tuberculosis	

Social History:

Tobacco use: yes___ no ____ amount____ how long _______ type __________

Alcohol use: yes___ no ____ amount____ how often _______ type __________

Street drug use: yes___ no _____ type/amount/dates used ______________________

Family History:

Adopted: yes/no Father: alive- yes/no Mother: alive- yes/no

Father health status:____

Mother health status:____

Siblings: # brothers __________# sisters: __________ Health status:_________________

____

Children # sons___________ # daughters_________ Health status:_________________

Gynecological(womens)History:

Date that last period began:________________ Date last period ended:________________

Last PAP smear:_______________________ Last mammogram:___________________

#Pregnancies:__________;# live births:__________; # miscarriages_____;#stillbirths_____

#Abortions:__________ , Date of hysterectomy _________________________

List of Surgeries

Type of Surgery& Hospital or town where performed:______________________________ Date __________

Type of Surgery& Hospital or town where performed:______________________________ Date __________

Type of Surgery& Hospital or town where performed:______________________________ Date __________

Third Coast
Family Practice
Craig Matheson, D.O.

Authorization for Release of Medical Information

I Hereby Request:

____
____
____
____
____
____

To Release Records To:

Third Coast Family Practice
Craig Matheson, D.O.______
821 West U.S. 10_________
Scottville, MI 49454_______
PHONE: 231-757-2500____
FAX: 231-757-9284_______

To release the medical records of the person listed below:

____

Full Name of Patient   Date of Birth

Reason For Release:

- ☐ Transferring care
- ☐ Coordination of Care
- ☐ Other ____

This authorization is subject to the following limitations:

_______ Confined to records regarding treatment for: _______________________________
Medical condition or injury/date

_______ Confined to records from _____________________to_______________________
Date   Date

_______ No limitations on dates, history of illness, or diagnostic and/or therapeutic information. Include any treatment for alcohol and/or drug abuse, AIDS and ARC (AIDS related complex), and psychiatric treatment. All records, or a minimum of the past ten years are requested.

This authorization must be signed by the patient if the patient is 18 yrs or older. For children under age 18, this authorization must be signed by custodial parent/legal guardian. Release is good for one year from the date signed.

Signature: ____

Relationship to patient: ___________________________________Date:________________

Witness: ____

FAXED________________

Since 2011, Third Coast Family Practice has maintained designation as a **PATIENT CENTERED MEDICAL HOME**. This national model for delivering care recognizes that the best health care is the result of a **Patient-Provider Partnership**. That means that You and your Third Coast Team work together to keep you healthy, share information, use appropriate preventative services, and successfully manage illnesses. By working together, we mean:

As your Medical Home, we trust you to:

- Ask questions, share your preferences, and be part of your care.
- Provide timely updates to changes in your personal information and insurance.
- Be honest about your medical history, symptoms, and how you take your medications. Tell us of any vitamins, supplements, or illegal drugs you use. Tell us promptly of any changes in your health or well being.
- Call us first before using Urgent Care or the Emergency Department.
- If your memory isn't good, bring an advocate with you to appointments.
- Take all your medicine and follow your medical provider's advice. Tell us if cost or some other reason is preventing you from following treatment recommendations.
- Make healthy decisions about your daily habits and lifestyle.
- Be sure to tell us about treatments, medicines or testing provided by other doctors.
- Be timely and keep your scheduled appointments. Come prepared with questions and reschedule in advance if necessary.
- Call your Medical Home FIRST with all medical problems, unless it is a medical emergency.
- End every visit with a clear understanding of your doctor's expectations, treatment goals, prescriptions needed and future plans.

As your Medical Home, you can trust us to:

- Explain diseases, treatments, and results in an easy to understand way.
- Assist you in making healthy decisions about lifestyle and health care matters.
- Keep treatments, discussions and records private.
- Provide 24 hour access to medical care and same day appointments for urgent medical needs.
- Provide considerate, respectful, and high quality medical care. Send you to trusted experts when needed and coordinate your care with them.
- Respect your cultural, spiritual and personal values, and preferences.
- Respect your time. If the physician is running late, you will be notified and given the opportunity to reschedule.
- End every visit with clear instructions about expectations, treatment goals, prescriptions needed and future plans.

I have read and understand this Partnership Agreement, and agree to abide by its guidelines:

____ _________________________

Signature of Patient or Responsible Party Date

July 7, 2021

RE: Emergency Room Visits v On-Call Provider by Telephone

Dear New Patient,

Doctors, hospital and insurance companies are working together to encourage patients to seek the most appropriate level of care for their needs. You may not always know when it is better to go to a hospital emergency department, or when you should contact us first. The purpose of this letter is to provide you with some information that we hope will help you navigate that decision.

Whenever you need health care, we encourage you to call our office first (231-757-2500). If the office is open we can help by either scheduling you to be seen that day, or by providing triage and treatment recommendations over the phone. This year we extended our business hours and have increased access to Same Day appointments:

Mondays	**8:15 am – 5:00 pm**
Tuesdays	**8:15 am – 5:00 pm**
Wednesdays	**Noon – 7:30 pm**
Thursdays	**8:15 am – 4 pm**
Fridays	**8:15 am – 4 pm**

If the office is closed, a recorded message will give you instructions including how to speak with us by telephone after hours so that we can make a decision together about whether or not you need to go to the Emergency Department.

The only time we would not want you to call us first, is if the circumstances require a call to 911 so that an ambulance can attend to you immediately. Examples of this type of circumstance would be: symptoms of a stroke or heart attack, loss of consciousness, trauma resulting in uncontrolled bleeding or inability to walk.

I hope this information helps you to make good choices about when it is necessary to go to the hospital for care. If we can be of any further assistance, please do not hesitate to contact us.

Sincerely,

Craig K. Matheson, DO, PLLC, and
Susan L. Persson, PA-C

821 West U.S. 10 Scottville, Michigan 49454 (231) 757-2500 Fax (231) 757-9073