TERENCE B THOMPSON, MD

Diplomate, American Board of Family Practice

Welcome Letter

Welcome to my office!

Find out more information on the web at www.ThompsonFamilyPractice.com.

Office Hours

Monday to Friday: 9:00 AM to 12:30 PM
Monday and Thursday: 2:30 to 5:00 PM

After Hours

I am on call for this practice 24 hours a day, Monday through Friday. If you are having a life-threatening emergency dial 911 first. I can be contacted by the Emergency Room after you are stabilized. For urgent matters, please call the main office line, 818-341-0670, and the voicemail will give directions on contacting either myself or the on call physician.

On selected weekends, holidays and vacations Dr. Susan Hopkins covers patient needs for my office. Information on contacting her or a covering physician can be heard on the voicemail of the mail office line.

Should you need the services of an Urgent Care, I recommend the **Urgent Care at HealthCarePartners** (18433 Roscoe Blvd #206, Northridge, CA 92618, 818-341-1540). Besides most PPO plans, they are also contracted to see HMO patients through Northridge Medical Group.

In more urgent situations or emergencies and if it is practical and safe for you to travel, I recommend Northridge Hospital Medical Center Emergency Room.

Refills for routine medication will be done ONLY during regular office hours.

Extended Care

If you are in need of hospitalization, I admit my patients to **Northridge Hospital Medical Center**. My preferred nursing home is **Brookdale Senior Living** in Northridge. My preferred hospice care is **ProCare Hospice**.

Payment

Your co-payment or deductible is due at time of service in the form of **CASH or CHECK ONLY.** Please remember that the individual patient is ultimately responsible for payment of the the medical bill. Currently the office accepts and bills many insurances companies. You may find a complete list on our website.

For those who pay for their medical care entirely out-of-pocket, we have reasonable cash fees.

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Privacy

It is our policy not to share your medical information with anyone that we do not have your express written permission to do so. This includes a spouse or other family members. Your medical file is kept in an electronic format in a secure server. Wireless transmissions in this office are on a protected/encrypted system. We may share information about you without your express permission in the following circumstances:

1. With specialist physicians that will be providing care to you.
2. With your health plan especially in regards to payments, referrals or quality assurance purposes. Usually you will have already signed consent with your health plan allowing them access to your medical records.
3. If you pose a danger to yourself or others.
4. If your records are subpoenaed by a court.
5. If there is suspicion about spousal, child, or elder abuse. Please be advised that I am a mandated reporter for abuse in California.

Please be aware that when you fill your prescriptions this information can be tracked by your insurance plan, pharmaceutical companies, and the State of California. Information about your health can be inferred from this data. This is not under my control.

Ethics

You should receive a copy of the Patients' Bill of Rights.

Please also note that because of my Christian beliefs and my understanding of medicine and medical ethics, I am unable to perform, refer or counsel in the favor of abortions. This includes the prescription of the "morning-after" pill. If you feel you may need these services from me now or in the future you should consider seeking a different medical provider.

Thank you for allowing us to serve your healthcare needs!

Dr. Thompson and Staff

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Patient Information

Name: Last_____First_____MI____

Date of Birth_____Soc. Security Number_____

Address: Street_____City_____Zip_____

Phone Numbers: Home_____Work_____Cell_____

Marital Status:_____Employment Status:_____

Employer/School Name:_____

Employer/School Address:_____

Primary Insurance Policy:_____

ID Number:_____Group Number:_____

Emergency Contact:_____Phone Number:_____Relationship:_____

How did you find out about our office?_____

Past Medical History (please include any significant disorders, illnesses, or surgeries):

Please list the medication that you are now taking. Please include the name, size of tablet, and how often you are taking it:

Allergies to any medicines or substances including food or latex allergies:

Significant family history:

Signature of Patient or Authorized Person (parent if minor):

X_____Date:_____

NORTHRIDGE MEDICAL SUITES * 8833 RESEDA BLVD. SUITE A* NORTHRIDGE, CA 91324
PHONE: 818.341.0670 * FAX: 818-341-0690

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Patient Consents

Patient_____DOB:_____Chart No._____

General Consent:

I have received a copy of Dr. Thompson's welcome letter. I understand that I am responsible for any medical charges that I incur including insurance co-payments and costs incurred that my medical insurance does not cover. I also give permission to Dr Thompson to obtain my medical history, perform a general medical exam and to prescribe or administer any treatment that he believes is in the interest of my medical health.

Signature of Patient or Authorized Person (parent if minor):

X_____Date:_____

Insurance Benefits Release of Information and Authorization to Pay:

I authorize the release of any medical records or other information necessary to process claims for treatment from Dr. Thompson. I also request payment of government (or other insurance) benefits to Dr. Thompson. I also authorize payment of medical benefits from any secondary insurance source to Dr. Thompson for treatment rendered to me.

Signature of Patient or Authorized Person (parent if minor):

X_____Date:_____

Consent to Discuss Treatment:

I give Dr. Thompson permission to discuss my medical care with:

Name:_____Relationship:_____

Name:_____Relationship:_____

Exceptions:_____

_____

☐ Please do not discuss my medical care with anyone else.

Signature of Patient or Authorized Person (parent if minor):

X_____Date:_____

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