THRELKELD, THRELKELD & OMER, PLLC

Michael Threlkeld, MD
Stephen Threlkeld, MD
Imad Omer, MD
William Mason, MD

Anita Arnold, MD
Janet Mulroy, ACNP
Kate Snyder, FNP
Lisa Woodcock, ACNP

Marah Watts, FNP
Ashley Marion, FNP
Tracy McClinton, DNP
Nelum Walker, FNP
Beverly Jones, DNP

Patient Information Sheet

Date______________________

NAME: LAST ________________________________ FIRST_____________________________ MIDDLE INITIAL __________

ADDRESS ____

CITY ____ STATE _______________ ZIP________________________

HOME PHONE ________________________________ CELL PHONE ________________________________

WORK PHONE ________________________________ EXT. ______

EMAIL (required for patient portal access) ____

PRIMARY CARE DOCTOR ____

REFERRING PHYSICIAN ____

DATE OF BIRTH _______________________ SEX _______ SOCIAL SECURITY# ______________________________

PREFERRED LANGUAGE_______________________________ RACE______________________ ETHNICITY____________

MARITAL STATUS: ____________________________________

EMPLOYER NAME ____ ADDRESS __________________________________

EMPLOYMENT STATUS: ____
(Full Time/Part Time/Non-employed)

STUDENT STATUS: ____
(Full Time/Part Time)

RESPONSIBLE PARTY: ____ RELATIONSHIP __________________________

NAME _______________________________________ ADDRESS ____

CITY ____________________________________ STATE ___________ ZIP ________________ DOB __________________

EMERGENCY CONTACT:

NAME: LAST _______________________ FIRST ______________________ RELATIONSHIP ___________________

ADDRESS ______________________________ CITY ____________________ STATE ________ZIP _______________

HOME PHONE ______________________________WORK PHONE ___________________________ EXT. ____

PERMISSION TO LEAVE MESSAGE: Home _____________________ Work ________________________________
(Yes/No) (Yes/No)

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I AUTHORIZE THRELKELD, THRELKELD AND OMER, PLLC TO ACCESS PRESCRIPTION/MEDICINEHISTORY:

YES_____________________ NO_______________

PREFERRED PHARMACY:

NAME ___________________________________ LOCATION ____

PHONE __________________________________ FAX _________________________

PRIMARY INSURANCE ________________________ POLICY HOLDER NAME _________________________________

POLICY HOLDER SEX _________________________ POLICY HOLDER DOB __________________________
(Male/Female)

POLICY HOLDER SSN#_______________________ POLICY HOLDER RELATIONSHIP TO PATIENT____________

ID# ____ GROUP # ____

SECONDARY INSURANCE _____________________ POLICY HOLDER NAME _________________________________

POLICY HOLDER SEX ________________________ POLICY HOLDER DOB __________________________
(Male/Female)

POLICY HOLDER SSN#_______________________ POLICY HOLDER RELATIONSHIP TO PATIENT____________

ID# ____ GROUP # ____

I HEREBY GIVE LIFETIME AUTHORIZATIONS FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE PAYABLE DIRECTLY TO: **THRELKELD, THRELKELD & OMER, PLLC** AND ANY ASSISTING PROVIDERS FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTION AND REASONABLE ATTORNEY'S FEES.

I also understand that I must give 24 hour notice of cancellation for any drug infusion. Otherwise, I will be responsible for any drugs costs not reimbursed by my insurance. If I am more than 30 minutes late for my infusion, my infusion may not be able to be administered that day and I will be responsible for drugs costs not reimbursed by my insurance. I further agree that if I am late for an appointment for infusion more than **three (3) times**, the practice reserves the right not to accommodate me for any further infusion therapies.

All No Show appointments are assessed a $75.00 fee in addition to any billable medicine charges.

I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

My signature below acknowledges that I have read and agree in entirety to the above office policies.

Signature: ________________________ Date:___________________