Third Coast
Family Practice
Craig Matheson, D.O.

Dear New Patient:

Thank you for choosing Dr. Matheson at Third Coast Family Practice as your Primary Care Physician. The purpose of this letter is to acquaint you with some of our policies and acquire a little bit of information from you to prepare for your first visit and establish a new chart.

Obtaining Your Medical History

Before seeing you for the first time, Dr. Matheson would like to learn more about your medical history by obtaining your chart from every physician you have seen in the past ten years, plus the documentation of any surgeries, emergency room visits or hospitalizations. We are happy to assist you in this process. One of the forms enclosed is an Authorization to Release Medical Information. Please sign this form and copy as necessary to present one to each health care provider to send us your records. If you would prefer, you can give us the signed form with a list of providers; we will then fax it to everyone on your list and follow-up until the records are received. **We will not be able to schedule a new patient appointment without your records from your previous physicians. No medication refills can be ordered until you are seen by Dr. Matheson.**

Establishing Your New Chart

You will find four forms attached to this letter we ask you to complete to establish your chart. First, is a brief history form. The second give us information on how to contact you, permission to treat you, how to bill you, and other pertinent information. This form refers to our Notice of Privacy Practice and asks you to acknowledge that these policies have been shared with you (this policy is posted on this website and is always posted in the waiting room). Third, is the Authorization to Release Medical Information, explained above. Finally, there is our Payment Policy that we ask you to read and sign. All three forms can be returned with the Authorization to Release Medical Information. At this time, you may want to check if Dr. Matheson participates with your insurance plan, or discuss discounts available for self-paying patients.

The Day of Your Appointment

When you come in for your appointment, please bring all current medications with you in their original containers so that we know what you are taking. Once you have been seen for your first appointment, you will be able to obtain “Same Day” appointments for urgent care as needed.

We will look forward to meeting you on your first appointment, and providing you with thorough compassionate care.

Sincerely,

Craig Matheson, D.O., PLLC
Third Coast Family Practice

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Complete this form entirely to ensure correct billing

Name_____Gender: Male_____Female_____Transgender_____
DOB_____ SS#_____
Address_____City_____State_____Zip_____
Phone#_____ Cell Phone# _____Work#_____
Email Address: _____
Employer:_____Marital Status:_____
Preferred method of contact: □ home phone; □ cell phone; □ text message; □ patient portal
Emergency contact name_____relationship_____Phone#_____

What is the name of your primary insurance carrier?_____ Policy # _____
What is the name of the insured on the primary insurance carrier?
Insured's name_____DOB_____SS#_____

What is the name of your secondary insurance carrier?_____ Policy # _____
What is the name of the insured on the secondary insurance carrier?
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 the provider at Third Coast Family Practice to examine me and render medical treatment deemed necessary for evaluations, management and treatment of my medical conditions. ___ ___
- I authorize the provider 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_____

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Payment Policy

1. Insurance: Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage and for all hospitalizations. Please refer to the list of insurances with which our office participates. 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 claim is your responsibility whether or not your insurance company pays your claim. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. Your insurance benefits are a contract between you and your insurance company; we are not a party to that coverage.

2. Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. A $10.00 surcharge will be added to your account if co-payments are not made at the time of service.

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 and persons for whom office visits are a Non-covered service:
   - A 15% discount will be granted if payment in full is received on the day of service
   - At your 1st new patient visit a $70 deposit is expected prior to being seen by the doctor
   - Your account balance will be limited to $100 and must be paid in full within 30 days

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 notifying you of your patient balance. Payment is expected within 30 days. Payment plans are a courtesy that may be offered by the Finance Director if requested in advance. Partial payments will not be accepted unless previously negotiated. 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.

7. Fees: The following fees will be assessed:
   - FORMS- A $10 fee is required for completing forms in between office visits.
   - COPAY SURCHARGE- A $10 fee for failure to remit copay at time of service.
   - 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

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Health History Form

Name:_____DOB:_____

Race:
__ American Indian or Alaska Native
__ Asian
__ Native Hawaiian Or Other Pacific Islander
__ Black or African American
__ White
__ Decline to specify

Ethnicity:
__ Hispanic
__ Non-hispanic

Primary Language:
__ English
__ Spanish

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	Asthma	Hypertension	**Adult immunization dates:**
Allergies	Artificial joints		Last Tetanus_____
Cancer	Stroke	Pacemaker	Last pneumonia shot_____
COPD	Diabetes	Jaundice	Last Flu shot_____
Gout	Glaucoma	Heart disease	
Jaundice	Seizures	Implants(breast/other)	
Tuberculosis	Thyroid disease	High cholesterol	

Social History:

Tobacco use: yes____ no ____ Chew ____
Alcohol use: yes_____ no _____ amount _____
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 of last period began:_____ Date last period ended:_____
Last PAP smear:_____ Last mammogram:_____
#Pregnancies:_____;# live births:_____; # miscarriages_____;#stillbirths_____
#Abortions:_____

List of Surgeries

Type of Surgery_____ Date _____
Type of Surgery_____ Date _____
Type of Surgery _____ Date _____

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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_____

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Third Coast Family Practice strives to be your **PATIENT CENTERED MEDICAL HOME**. This national model for delivering care recognizes that the best health care is the result of a **Patient-Provider Partnership**. A Medical Home is the hub of all information and communication so that you and Dr. Matheson can work together to keep you healthy, use appropriate preventative services, and successfully manage illnesses.

As your Medical Home, we trust you to:

- Ask questions, share your feelings 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. 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 Dr. Matheson's advice.
- 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.
- Listen to your concerns and questions. 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 instructions on how to meet your health care needs when the office is not open.
- 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.