



Michele M. Thompson, MD
DERMATOLOGY

IN ORDER TO BILL YOUR INSURANCE WE MUST HAVE THE SUBSCRIBERS INFORMATION BELOW

Primary Insurance: _____ **Member ID Number:** _____

Policy holder: _____

NAME

DOB

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Secondary Insurance: _____ **Member ID Number:** _____

Policy holder: _____

NAME

DOB

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIALLY RESPONSIBLE PARTY IF OTHER THAN SELF: _____

I attest that the information provided is to the best of my knowledge, true and accurate. I authorize Michele M. Thompson, MD LLC to release medical information necessary to process my insurance claim (if any). I hereby authorize payment of medical benefits to Michele M. Thompson, MD LLC when an assigned claim is filed. I understand that I am responsible for any amount not paid for by my insurance. I understand I am responsible for any known visit co-pays at the time of service.

By signing this form, I authorize the physicians, agents and employees of Michele M. Thompson, MD LLC to provide medical or surgical care and services, including, but not limited to, diagnostic tests, examinations and other medical and surgical procedures in the course of my medical care. I agree to comply with the plan of care/ services to which I have consented. I agree I have reviewed and understand the Notice of Privacy Practices (HIPAA). A paper copy has been offered to me.

I authorize Michele M Thompson, MD LLC and its providers to access my prescription medication history through Surescripts and other authorized pharmacy benefit and prescription history services. This information may include current and past prescription medications obtained from pharmacies and pharmacy benefit managers and will be used solely for purposes of treatment, care coordination, medication reconciliation, and patient safety. I understand that this authorization is voluntary and that I may revoke it at any time by notifying the practice in writing, except to the extent action has already been taken based on this authorization. I acknowledge that accessing my prescription history helps my healthcare providers make informed and safe treatment decisions.

Patient or Responsible Party Signature

Date