WILLIAM NOYD, MD

GENERAL PATIENT INFORMATION

Date:____________________ **Medication Allergies:** ______________________________

Patient's First Name:______________ **Last Name:**____________________ **Middle:** __________

Home Phone: ( )______________ **Cell Phone: ( )**__________

Street Address: City:__________________**State:**____ **Zip:**_____

Date of Birth: __________**Social Security Number:**________**Sex:** ___

Marital Status: Single Married Widowed Separated Divorced

Employed By:________________________ **Work Phone:** __________________

Employer Address:____

Referred by:____

Other Family Members seen in this office:__________________________________

IN CASE OF EMERGENCY, NOTIFY: Name:____________________**Relationship:**______ **Phone:** ______

Street Address:____________________**City:**____________ **State:**_____ **Zip:**__________

INSURANCE INFORMATION

Primary Insurance Company:____________________________ **Please give card to Office Staff**

Subscriber's Name: _______________________ **Subscriber's Social Security Number:**______________

Relationship to Patient: Self Spouse Child Other

Self Pay

INSURANCE ASSIGNMENT and ACKNOWLEDGEMENT

I authorize payment of medical benefits to the practice of William Noyd, MD PC for professional services rendered. I authorize release of medical information necessary to process medical claims. I acknowledge the receipt of notice of privacy practices any my signature below verifies HIPPA disclosure. If the insurance information I have supplied is inaccurate or invalid, I assume full financial responsibility. For those carriers with whom we do not participate, payment will be due in full at the time of service. Participating insurance carriers are to process and pay claims correctly within 30 days of submission. After this time, all outstanding balances become the responsibility of patient.

We are committed to providing you with the best medical care and service. As a courtesy, we require 24 hour notice for the cancellation of a scheduled appointment. There will be a $35 charge for the lack of notification. If you fail to keep an appointment for a complete physical, you will be assessed a $100 charge. This will be your responsibility and will not be billed to your insurance company.

A $35 service fee will be assessed from any returned check and we reserve to the right to require cash or credit card payment in lieu of accepting subsequent checks.

Should your insurance company not fully reimburse the cost of a special lab test, you will be responsible for the difference between the covered amount and our cost.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:________________________ **DATE:** ________________________