Fred M. Novice, M.D. - Dermatology

Patient Information - (Please Print Clearly)

Name: _____ DOB: _____ Male ☐ Female ☐

Address: _____ City: _____ State____

Zip: _____ Phone: (Home)_____ (Work)_____

(Cell)_____ Employer: _____

Email Address: _____

Referred By: _____

Emergency Contact: Name_____ Phone: _____

Authorization to Release Information to Your Emergency Contact: _____
Signature

Relationship to Patient _____

This office participates in many insurance plans. If Fred M. Novice, M.D. is contracted with your insurance company we will accept their negotiated rate for the charges billed, however, you will be responsible for any balance deemed patient responsibility/non payable/not covered by your insurance. There are a variety of deductibles and copays which are the responsibility of the patient or responsible party and are collected on the date of service when permitted. Our office will bill the total charges showing the payment received. If no amount is applied to the deductible or copay you will be reimbursed either by our office or your insurance company. If the service is rejected by your insurance company, you or the responsible party will be responsible for all fees. Please keep in mind that many insurance companies determine the fee by diagnosis and procedure not by time spent or complexity. Remember all insurance claims are subject to individual plan terms and provisions.

Authorization to Release Information: The undersigned hereby authorizes Fred M. Novice, M.D. to release all information pertaining to patient's treatment to his/her insurance company or companies and to any other Physician or Health Care Providers to whom the undersigned may be referred. I authorize Fred M. Novice M.D. to process claims and request payment to be assigned to Fred M. Novice, M.D.

Fred M. Novice, M.D. may disclose pertinent health information about me when required to do so by federal, state, or local agencies or in response to a court or administrative order in response to a subpoena. I acknowledge receipt of my notice of privacy practices for the office of Fred M. Novice, M.D.

Patient Signature: _____ Date: _____

Responsible Party: _____Relationship: _____
(Legal Guardian)

NO CHANGES Signature _____Date_____

NO CHANGES Signature _____Date_____

NO CHANGES Signature _____Date_____